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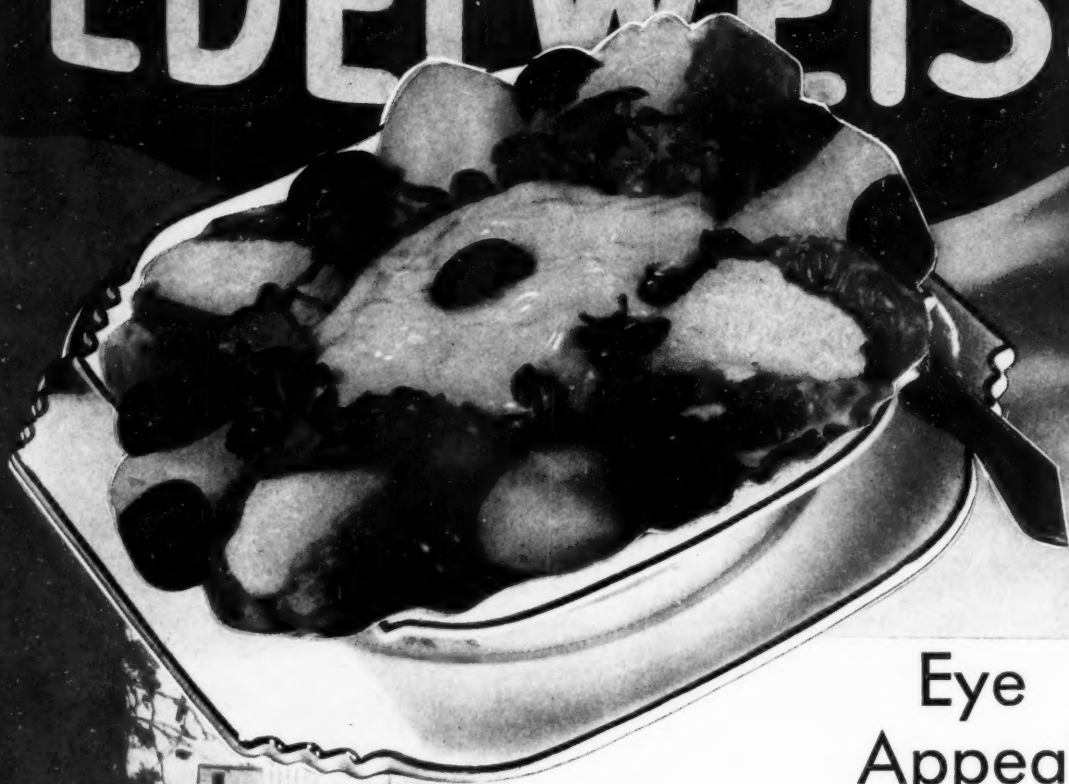
The
**MODERN
HOSPITAL**

Volume 43

SEPTEMBER, 1934

No. 3

EDELWEISS



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For September, 1934

Just in Passing—

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HAS hospital standardization reached its limit of usefulness? Probably no one acquainted with the facts would admit for a moment that this is true so far as the great majority of hospitals is concerned. For the few at the very top and the larger group just below them, however, there is good reason to believe that little more stimulus to progress will come from further efforts at standardization.

The hope of further progress—and we must have it if we are to live—seems to lie in intelligent differentiation. Hospitals that have realized fully all the requirements of standardization should now consider how they may render distinguished service to their communities. Doctor Ball's article on page 49 sets the problem. The MODERN HOSPITAL is asking 250 of America's leading administrators to supply the answer. You will hear more about this subject shortly.

LAST month Mr. Addleman displayed some of the shortcomings of previously accepted fund-raising efforts. His article has been criticized as not constructive. Perhaps it wasn't by itself. But this month's article builds on the groundwork laid by the first one (page 73). The concluding article will appear in October.

A COMMITTEE on economics of the Canadian Medical Association recently submitted to the association a plan for compulsory state health insurance. This is now being discussed by the provincial associations before any action is taken by the parent body. While it might be a great surprise if the American Medical Association adopted such a procedure, the

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arguments for compulsory health insurance are pretty convincing. Mr. Chenoweth summarizes them briefly on page 59.

WHAT sort of fellow is the psychiatrist and what can he do? Henry Phipps Institute at Johns Hopkins Hospital occupies a position of distinguished leadership in the field of psychiatry. Doctor Muncie who is now on the teaching staff at Phipps has a clear answer to both these questions (page 41). Small hospitals as well as large ones should consider the application of his article to their needs.

OF COURSE you are going to the convention. Doctor Doane tells you a little about Philadelphia's rich and colorful medical history in the article on page 67. The program is given on pages 64 and 65. Study this carefully. While in Philadelphia you may like to attend the Protestant meeting, too. You will find its program also in this issue.

NEXT month Dr. B. W. Black of Oakland, Calif., will outline the abilities that will be expected of the hospital superintendent in the future.

ST. PAUL has built up a group hospitalization plan that is, apparently, on a sound basis. It is unusual in that volunteers have been used extensively. Next month Mr. Van Steenwyk, the director, will describe the plan in detail.

DIRECTOR and architect unite to describe the transformation of an outgrown plant, and two authorities evaluate their accomplishments in the construction article for October. By Dr. H. M. Ginsburg and Fred L. Swartz, the article describes the modernization of the Fresno County Hospital, Fresno, Calif.

IN ADDITION to these features the magazine will devote sixteen full pages to a report of the Philadelphia meetings and the im-

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portant business that will be transacted there. Some of the leading papers of the convention will be published.

A SPECIAL feature of the dietetic department the past twelve months has been the series of monthly dinner menus. The last of these comes this month. Starting next month there will be a series of breakfast and supper menus written by the same dietitians who prepared the dinner menus. These are to be planned so that the breakfast, supper and dinner menus for any particular day will provide harmonious balanced meals for the day.

FLASHES FROM THIS ISSUE:

"The building was erected by organized labor. The men accepted in lieu of cash, nonnegotiable hospital scrip to be used for hospitalization by themselves or members of their families." *Page 78.*

"In the nurses' homes on the Continent, each girl is encouraged to express her own individuality in her room. They are not like hotel bedrooms, but are simply furnished." *Page 82.*

"It is to the interest of all concerned for the superintendent to become generally aware of the basic facts relative to the scientific work of the hospital, to keep a mind alert to new developments and an attitude that never discourages but always encourages and stimulates others to progress." *Page 87.*

"Each year, on the day before Thanksgiving, Princeton Methodist Hospital conducts a drive for linens, fruits, vegetables, jellies—in fact, everything that is used in housekeeping." *Page 89.*

"Adjustment to current economic conditions is only a highfalutin way of saying adjusting the patient's quarters to his and the hospital's pocket book." *Page 93.*

"With proper care, gas anesthetics may be administered at no greater expense than ether anesthetics." *Page 112.*

THE MODERN HOSPITAL

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The Hospital Barometer

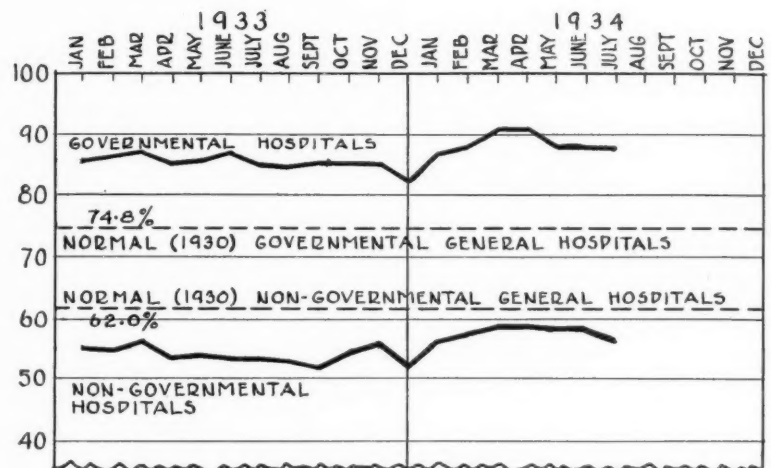
Although nongovernmental general hospitals reported a slight seasonal decline in occupancy in July, the figures were still well above the level for July of last year. The occupancy figure for governmental hospitals remained almost the same. The general average, however, is not very revealing in this instance since most of the areas reported declines, but New Orleans reported a large enough increase to overcome them.

Only seven new construction projects were reported between July 30 and August 20. Four of these were for new hospitals, of which three reported costs of \$205,000 and the other three were small additions to existing hospitals totalling \$43,000. This is the smallest number of new hospital building projects reported in the last eighteen months.

Production and trade fell off more than seasonally in July and the first two weeks of August, according to the monthly report of the National Industrial Conference Board. Automobile output, building construction, steel and iron production, textile output and bituminous coal production declined by amounts larger than seasonal. Electric power output, on the other hand, fell off less than expected.

Unemployment, which started to increase in June after a long decline, increased still further in July, the Board reports. At the peak of unemployment in March, 1933, the Board estimated that there were 13,203,000 persons employable but without work. By July, 1933, this figure had dropped to 11,416,000 and by May, 1934, to 7,845,000. In June the number rose to 7,934,000 and in July to 8,609,000.

The wholesale commodity price index of the *New York Journal of Commerce* reached a new high in the week end-



ing August 25, touching 79.0 (1927-1929=100). This practically equals the level on August 23, 1930, when the index stood at 79.7. During August grain prices advanced sharply, the index going from 78.5 on July 21 to 88.4 on August 25. Food prices in general also advanced but at only about one-half the speed of grain. Textiles and fuel remained at approximately the same level and building materials declined slightly, the index going from 95.4 on August 21 to 92.5 last week. The price index of drugs and fine chemicals compiled by the *Oil, Paint and Drug Reporter* remained practically unchanged.

The abandonment of price-fixing practices under NRA, which appears imminent, and the increased recognition in Washington of consumer interests may bring lower prices of manufactured goods, although increased costs of labor and of raw materials will work in the opposite direction.

OCCUPANCY FIGURES OF HOSPITALS IN VARIOUS STATES AND CITIES

Type and Place	Census Data on Reporting Hospitals ¹		1933							1934						
	Hospitals	Beds ²	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	April	May	June	July	
Non-Governmental																
New York City ³	68	15,194	64.0	62.0	62.0	65.0	68.0	65.0	69.0	70.0	73.0	75.0	75.0	75.0*	75.0*	
New Jersey.....	58	9,772	57.0	57.0	56.0	58.0	61.0	57.0	58.0	62.0	63.0	63.0	63.0	61.0	61.0*	
Washington, D. C.....	9	1,763	55.3	54.5	55.5	58.9	59.3	57.7	61.7	65.0	67.2	65.8	62.8	62.8	58.4	
N. & S. Carolina.....	96	5,655	55.2	54.4	54.5	52.6	54.2	51.3	54.0	57.3	59.2	59.4	59.6	62.1*	62.6*	
New Orleans.....	7	1,178	46.7	45.5	43.4	43.3	44.9	43.1	42.4	43.4	46.5	42.1	43.2	48.4	43.3	
San Francisco ⁴	13	2,430	52.7	53.7	54.3	56.3	58.1	53.9	59.5	63.0	61.9	61.6	60.3	58.1	56.8	
St. Paul.....	7	1,128	43.4	44.4	41.0	44.7	48.8	46.0	51.8	53.8	49.4	50.7	47.3	50.6*	44.9	
Chicago.....	23	5,968	50.0	49.4	48.1	50.7	51.5	49.1	53.1	53.5	53.3	55.4	56.5	57.7	57.3	
Cleveland.....	9	2,195	60.0	61.0	56.0	60.0	61.0	55.0	57.0	58.0	58.0	61.8	59.9	61.3	58.4	
Total ⁵	290	45,283	53.8	53.5	52.3	54.4	56.3	52.6	56.3	58.4	59.1	59.4	58.6	59.7*	57.5*	
Governmental																
New York City.....	16	11,618	100.1	100.7	101.9	103.3	106.6	104.5	100.7	100.0	105.0	103.7	101.9	93.7	91.3	
New Jersey.....	5	2,122	87.0	87.0	87.0	86.0	88.0	82.0	89.0	94.0	93.0	91.0	90.0	86.0	86.0*	
Washington, D. C.....	2	1,076	83.9	77.5	85.5	83.8	87.6	87.8	87.1	88.3	83.2	84.3	84.7	84.7	79.0	
N. & S. Carolina.....	13	1,136	58.2	58.2	55.5	58.2	56.6	50.6	58.6	65.8	66.4	66.8	64.5	69.4	70.6	
New Orleans.....	2	2,221	121.4	121.9	122.6	111.1	105.3	96.8	106.6	112.5	129.5	136.4	127.1	137.9	148.7	
San Francisco.....	3	2,315								77.4	79.2	76.7	80.7	77.7	76.4	
St. Paul.....	1	1,050	67.1	67.9	67.6	74.4	71.1	72.4	79.8	78.5	76.9	76.3	76.1	73.2	69.0	
Chicago.....	1	3,101	79.4	79.3	77.9	80.9	81.3	80.6	92.8	94.3	93.2	94.6	91.1	87.5	84.8	
Total ⁵	43	24,639	85.3	84.6	85.4	85.4	85.2	82.1	87.8	88.8	90.8	91.2	89.5	88.8	88.2*	

¹Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. ²Including bassinets, in most instances. ³Includes only general hospitals. ⁴Includes only 9 hospitals with bed capacity of 1845 through November, 1933. ⁵The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOLUME 43

September, 1934

NUMBER 3

The Hospital Psychiatric Consultant

By WENDELL MUNCIE, M.D.

Johns Hopkins Hospital, Baltimore

IN THE last two or three years a great deal has been heard concerning the interrelations of general medicine and psychiatry, and especially of the penetration of the fields of general medicine by psychiatry. At the recent meeting in New York of the committee on psychiatric education of the National Committee for Mental Hygiene, this aspect loomed large. Medical teaching centers throughout the United States are embarking on programs looking to the rapprochement of general medicine and psychiatry. In sort, the subject is in the air, and perhaps this is a good time to make some observations arising from practical experience as a hospital psychiatric consultant.

In the first place, the present day commotion would be unnecessary had physicians of all breeds in the past remained true to the duty of ministering to people as well as to illnesses. When medicine as a science was wrested from the spiritual guardian, by common consent the physician appropriated to himself the body, and the priest, the mind. The fallacy of this division is apparent in that the object of study remains an indivisible unit, and any such division is an artefact, the product of the divider's own limitations of interest and outlook. The present day trend is the practical expression of the healthy reunion of the ancient priestly and medical interest in men as human beings, and specifically as sick ones, with complaints.

The psychiatrist — a comparatively new protag-

onist of the psyche — does not work with a hypothetical mind but with human beings living and doing, with their satisfactions and troubles. He is interested in facts — “those things which make a difference and can become factors” (Adolf Meyer), whether those facts be found in structure or physiologic workings of organs and systems or in the workings of the memories, anticipations and ambitions. He does not balk at the discovery of facts of whatever sort and is willing to put them to an experimental test for their validity.

With such a definition of the psychiatrist, it is somewhat difficult to understand why he has been so far removed from his colleagues and why he now is the object of so much attention in the general medical world. The answer is probably to be found in the propagation of the fallacy of the division of man into physical and mental, and a sensitiveness about submitting “mental” facts to trained observation, and their acceptance as scientific data. As long as the term “scientific” is reserved for what can be seen under the microscope or electrically recorded, and denied to those facts of human behavior that are instantly recognized as significant by virtue of our common experience, then progress in returning to the aim of treating people as well as diseases will be slow indeed.

The generations that saw this division into physical and mental also saw many individuals in both camps who recognized their need for the other.

Psychiatrists perhaps were more openly aware of the need for firm medical grounding. Physicians on the other hand were more content to rely on the art of medicine, as a thing which one might acquire but which was not teachable as a science. Today is seeing the growing recognition that psychiatrist and physician have similar aims, need similar training and perform comparable services. There will always be a need for the specialist, but a community of interests can be demonstrated in the most divergent groups.

Physicians have come to see the need of psychiatric help largely through contact with six types of cases, which will be described by giving examples from actual practice.

Six Types Needing Psychiatric Aid

1. Patients with physical complaints and no unusual physical findings constitute a large share of every physician's practice. The group has been the recipient of every new therapeutic enthusiasm. Most of them would be glad for a common sense investigation of so-called mental factors, and some are amused by or annoyed at the physician's search for disorders of teeth, tonsils, heart and gastro-intestinal tract. Most of such cases fall into three general categories.

Case I—An elderly man, stable, simple, the father of nine children, a tenant farmer, came to the hospital with pains through the chest and arms, not dependent on exertion. He had spent several weeks in bed at his physician's order because of "angina" and was given digitalis, without benefit. Physical examination showed him to be essentially normal. Investigation revealed that the pains were sharp, were brought on always by worry, and subsided when he was distracted from his worry. They developed in a setting of mounting financial burden of several years' duration, reaching the climax with the destruction of his last crops by flood, the death of his livestock by disease, and virtual starvation facing the family. In this situation he became worried and depressed, slowed up, became sleepless, lost weight, and then suddenly developed the pains, which were the first warning that he could understand that things were not going well with him.

With supportive treatment, stressing his physical integrity and a working out of his immediate problem through relief, he gradually regained his emotional poise and habitual optimism, and the pains disappeared.

Such a case represents a distinct episode in a stable individual, characterized by melancholy, worry and apprehension, insomnia, weight loss, slowing of the bodily functions in general, with physical complaints reactive to heavy strains. Such a stable person is likely to be impressed by physical complaints as real, whereas the other features are disregarded, or interpreted as cowardice.

Case II—A stable, intelligent young woman for five years has been complaining of diffuse pains throughout her body, and fatigue. She has been the object of much fruitless medical manipulation, each year seeking a new cure and

keeping the family finances demoralized. Physical examination showed her to be completely normal.

Briefly, the patient's troubles began when her husband, a traveling salesman, decided to quit traveling. They settled in a pleasant small town. This would have pleased the patient entirely had not she found herself and their child the butt of her husband's increasingly frequent outbursts of uncontrolled temper. As long as he was traveling she had escaped to a great extent, and she fed her fancy with the picture of the ideal she held for him. Now she was at grips with the realities of the situation. Even short respite with visits to relatives was not possible because of her husband's demand that she always be at home when he was there, and he was always there. He was willing to spend all his money on medical treatment for her, but so far was unwilling to make any effort to change his own ways, or to let her have a portion of life to herself for her own use.

In this case is seen the development of physical complaints as a substitutive reaction for chronic disappointment and strain. This is the sort of reaction which tends to become fixed through habit formation and demands vigorous personality and situational adjustment.

Case III—A young woman has been complaining for three years of diffuse pains and fatigue, without physical cause, leading to progressive invalidism. The onset was shortly after she finished college, and her father's death. Both events are important, the former because she was thrown adrift to work out her own life with absolutely no goal or sustaining interest; the latter because she had depended heavily on her father's protection, and since his death the family financial position has suffered great blows, limiting her opportunity for distractions and her eligibility for marriage, and at the same time making her more aware of her lack of interests and her training for life. For her, however, the physical complaints constitute a sufficient reason for her failure to progress, and she preserves a complacent exterior, managing to secure unlimited sympathy from her fellows.

This case shows the development of physical complaints in a setting of a lifetime of goalless drifting, and a certain realization of the inadequacy of the life led, the complaints furnishing adequate justification for a continuance of the aimless living and so enabling the patient to preserve her self-esteem. This sort of case demands vigorous treatment through personality study, with stress placed on the development of goals and habit formation. It cannot be carried on successfully outside a psychiatric hospital.

Seeking Out Psychogenic Factors

There is no doubt that the investigation of psychogenic factors can help greatly in a better appraisal of that large group of complainers without physical justification for their complaints. The physician must have respect for facts of whatever sort they may be and must use them for what they are worth in an experimental formulation of the material. The facts are there, to be obtained for the asking, and universal common sense demands

their inclusion in the diagnostic formulation. No longer can the physician afford to interpret disturbances in human behavior as the exclusive result of tonsils, teeth, heart, stomach or glands of internal secretion, when the patient himself is aware of the psychogenic nature of the difficulty and is hoping for expert confirmation of his own diagnosis and help in unraveling the trouble.

Emergencies of Unexpected Behavior

2. The patient who shows unexpected and disturbing behavior causes distress to the physician and surgeon, and commonly the psychiatrist is called for help to put things right or to take the patient off the hands of the responsible physician.

Examples again will illustrate the major sorts of disturbances.

Case IV—A middle aged man was brought to the hospital for a fracture of the humerus. The arm was set and put up in splints. Twenty-four hours later the patient became confused, restless, talked incoherently, tried to get out of bed, spoke of seeing and hearing strange things, was disturbing to the other patients and could not be handled by the nurses. Physical examination showed tremor and tachycardia, but with no evidence for toxic influence from the wound or drugs used. The history showed the patient was a chronic alcoholic, and had been on a spree a few days before the accident. There had been coincident with the spree, poor sleep and no food intake. He passed through a typical delirium tremens episode for which he was transferred to the psychiatric department for his own protection.

This case illustrates the onset of intercurrent delirium in an otherwise uneventful illness, with disorientation, hallucinations and behavior disturbing to other patients. The suicidal risk is great in such cases, and they are best handled in a psychiatric hospital.

Case V—A young girl underwent an uneventful operation for hyperthyroidism with marked exophthalmos. A week later, because of corneal infection, the lids were sutured under local anesthesia. During the night following the operation the patient awoke, fearful, panicky, said she was being mistreated by the physicians and saw her mother standing by the bedside. She was oriented throughout. The episode was terminated with a large dose of barbiturate derivative and when she awoke thereafter she was able to accept reassurance and remained calm.

This case illustrates a common type of post-operative excitement and panic, in which the temporary loss of the use of both eyes leads to feelings of insecurity. Psychiatric help was useful in distinguishing the case from delirium, and in proposing the best means of treatment through immediate relief with sleep, and later reassurance.

Case VI—A school teacher in his early forties came to the hospital complaining of shortness of breath and fatigue, and was found, much to his astonishment and chagrin, to be suffering from luetic aortitis. He was somewhat downhearted at first but took his trouble philosophically and remained hopeful of the results of treatment. One night he suffered an anxiety attack, was suspicious of the atten-

tions of nurses and demanded his discharge. Consultation revealed that the patient was suffering from a paranoid jealousy reaction involving the alleged homosexuality of his wife. He had spoken unguardedly concerning his doubts of her to several people on the ward, and the anxiety attack resulted from his fear that too many people knew about his private life and were showing undue interest in his affairs. The psychiatric consultant was able to establish good rapport and thereupon urged discharge. The patient continued anti-lytic treatments after leaving the hospital, and simultaneously worked out with the psychiatrist his tangled life. A year later he was reestablished, at least temporarily, in home and job.

Ordinary medical and surgical wards are built for people whose behavior can be depended on not to render them unwholesomely conspicuous. When acutely disturbing and unexpected behavior arises, an emergency exists. Psychiatric consultation will help in the differential diagnosis of delirium, panic, paranoid states and other types of trouble, and so may point the way to the most effective therapy.

Mother Resents Son's Choice of Mate

5. Patients who enter general medical services recognizing their trouble as mental need special psychiatric help. Recently a patient who had been in a serious psychosis for several months was brought to the hospital for treatment of her ear. Her family had recognized her serious mental condition for some time but were afraid that any mention of it would upset her and had seized on the ear trouble as an excuse for hospitalization. The psychiatrist immediately established good rapport, and it developed that the patient had an excellent appreciation of her difficulties, and expected psychiatric help and transfer to the psychiatric hospital. Frequently, relatives are more sensitive to the suggestion of mental trouble than the patient himself, and admission to the general hospital is arranged often in self-protection under the guise of protecting the patient.

4. Patients with obvious physical troubles not responding well to therapy whose variations seem to depend on environmental and personality factors present a great difficulty. The physical manifestations are legion. One illustration will suffice.

Case VII—A woman in the fifties came to the hospital with a rather generalized cutaneous eruption, diagnosed as atypical lichen planus. Supportive treatment was helpful, but things went along slowly and variations seemed to be linked with the visits of her son. The patient blamed her condition on the fatigue caused by a long automobile ride over the mountains, through fog and rain. The facts were briefly: The patient's adored only son announced his intention of marrying a woman totally unacceptable to her. He was adamant against her protestations. Finally the patient and he took an automobile trip ostensibly to visit a relative, whom the patient hoped to enlist in her campaign against the marriage. This relative immediately sided with the son, and it was on the homeward trip, full of disappointment and tense at losing out, that the eruption began to

appear. Her condition rapidly became worse and finally forced hospitalization. She never gave up her warfare against the prospective daughter-in-law, and finally while in the hospital saw the beginnings of capitulation from her son. With this turn of events, the skin began to clear. In the far past there had been an episode of hysterical paraplegia, accompanied by the development of leukodermic spots, in a setting of special strain and disappointment.

This case represents a type of somatic disorder probably substitutive for a situation of psychogenic tension. Variation in the course corresponded closely with variations in the psychogenic tension. Psychiatric help in such a case leads to a careful appraisal of the situation and the development of insight in the patient.

5. Accident service often demands psychiatric help. Every case of attempted suicide should be seen in psychiatric consultation to determine the more general type of reaction in which the suicidal attempt was but an episode and to gauge the best disposition to be made of the case. Every case of delirium (*e.g.* delirium tremens) or of amnesia likewise needs psychiatric help. The accident service demands accurate diagnosis and quick treatment. Errors likely to be costly to the patient and to the hospital may be avoided if the psychiatric evaluation of the trouble and recommendations in the situation are heeded. The psychiatrist will be of help in the proper placing of patients needing further treatment in mental hospitals.

Controlling Foci of Social Disturbance

6. The field of disease prevention is demanding more and more attention. In any campaign toward this end, the contribution of the psychiatrist should not be overlooked. He can gather and interpret socially significant data that cannot profitably be disregarded. Experience shows that certain factors operate as foci of social disturbance and the control of these factors is just as important to human health and happiness as milk and water inspection.

Alcoholism, feeble-mindedness, inadequate school and recreational opportunities, racial and cultural prejudices and handicaps, adverse working conditions, religious strife, sex and other delinquencies all constitute well known foci of social infection. Let no one think he is immune from the effects of these foci. The vast toll in time, money, property loss and wasted opportunity is paid by everyone, regardless of his own apparent personal security.

Some opportunities for usefulness in psychiatric help have been noted above. They are to be found everywhere — in large and small hospitals alike. There will be a demand for the psychiatrist's help just as soon as physicians are willing to admit the essential unity of purpose of internist, surgeon and psychiatrist, namely, the restoration of the

individual to a useful and satisfactory life; and when the physician has allowed himself the opportunity of observing at first hand that the psychiatrist can make a definite contribution to the understanding and treatment of human beings in distress.

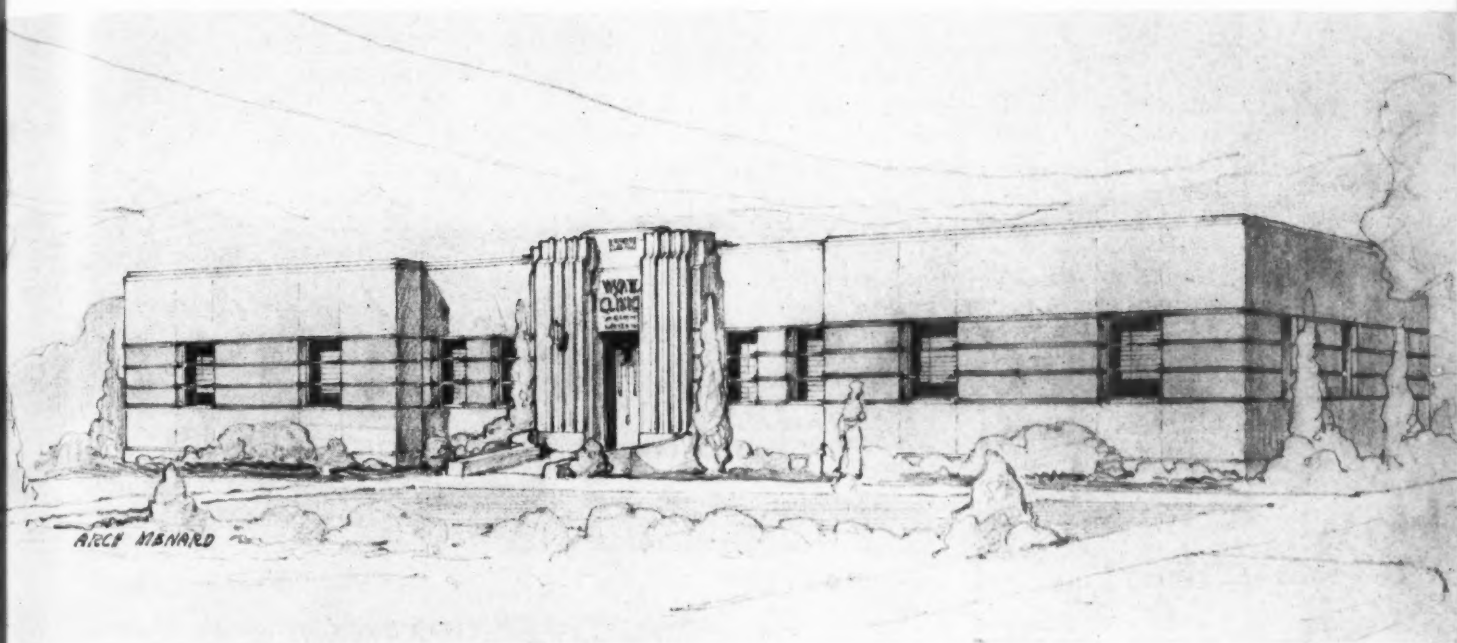
When a hospital or group of physicians have come to this conclusion, and a psychiatrist is sought, let the following considerations determine the choice.

Points to Weigh in Picking a Psychiatrist

1. The psychiatrist must have a firm grounding in general biologic and medical training.
2. He must be alive to the opportunities for mutual help between the branches of medicine.
3. He must have an interest in and knowledge of social organization, and be willing to become an active member of the society in which he works and lives, for the psychiatrist more than any other physician works with the dynamics of human living, and he can be of help only when his findings grow out of and are couched in terms of human experience. Beware of the psychiatrist (or any other physician) whose diagnoses exhale the odor of textbook dust.
4. He must have laid the ghost of the "mind-body" problem in his own life, live as a unit and see other people as units — not as so many bodies and so many minds with all the unwholesome distinctions deriving therefrom.

When this psychiatrist has been found, give him a chance to demonstrate his usefulness. The hospital or group organization can assist materially in this in the following ways:

1. Make him a real colleague, with an equal voice with internist and surgeon in the evaluation of the clinical material.
2. Give him the freedom of the hospital, so that he can develop his own interests.
3. Cultivate an attitude toward him and his work that will stress the common ground, rather than the distinctions, so that his presence in the hospital need occasion no more comment than the presence of internist or surgeon.
4. Give him an opportunity, yes, demand that he teach nurses and staff members some psychiatric fundamentals.
5. Give him special space and nursing facilities for handling psychiatric problems in the hospital. His usefulness will be stunted if his advice always has to recommend transfer to another hospital.
6. Be on the lookout for psychiatric problems and call him for help.
7. Give a vote of confidence in the unity of man and the unity of medical purpose by referring your own cases to him for consultation.



A Desert Clinic Planned for Patients With Arthritis

THE Wyatt Research Foundation holds a charter from the state of Arizona as a non-profit corporation "to conduct scientific investigations relative to the treatment and prevention of disease, particularly the arthritides, and the advancement of clinical and scientific medicine."

In view of the fact that the holdings and activities of this corporation are to be perpetuated on such a basis, it was highly important that its initial unit — The Wyatt Clinic and Research Laboratories — be developed in a manner that would take as long a look into the future as might be possible.

In addition to taking cognizance of factors of an essentially administrative character peculiar to corporations that are not organized for profit, construction methods and materials best adapted to clinics and hospitals established in desert climates were objects of consideration and investigation.

The comfort and well-being of both patients and staff members during the summer months were matters of fundamental importance, and most of the departures from the conventional building traditions and procedures of the Southwest re-

sulted from the efforts of the architect and the contractor to solve the various problems associated with the high atmospheric temperatures that characterize June, July, August and September.

Thick adobe or brick walls had long been considered essential to comfort; but those who planned this unit realized that modern semirigid fiber insulating materials only three or four inches thick and enclosing a four-inch dead air space will provide insulation equivalent to a forty-two-inch brick wall.

In addition to the employment of construction methods and materials with special reference to their insulating properties, many other considerations were entailed. Among them were facility of erection; flexibility; fire, dust and vermin proofing; noise-level control; shadowless and glareless illumination, and sanitation. There were, furthermore, the highly significant qualifications of a moderate capital investment plus economy and efficiency from the viewpoint of operating costs. At the out-

set it was discovered that several systems of construction embodied a number of these fundamentals, but that no single system could be found that included them all. The exterior of the build-

By
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Architect, Tucson, Ariz.

ing has an enameled steel facing of an essentially modernistic character. With the exception of the decorative motifs at the main entrance, the building design is limited to the emphasis of the horizontal lines, which are an integral part of the structure. It is believed to be the first building in the United States in which steel-clad insulation applied to a welded steel skeleton has been used as a medium for an architectural design predicated on its functional use.

With the exception of concrete foundation, walls and floors, no masonry, plaster or water enters into its construction.

To meet the exacting requirements of modern medical practice and research, all interior and exterior finishes are of a smooth, hard, sanitary type with a heavy insulated backing. Ceilings are of acoustical material that will control the noise level. Lighting fixtures are of the totally indirect type. All essential cabinets and cases fulfill modern laboratory requirements. Sanitary wall bases are installed throughout the building and all floors are finished with linoleum tile.

Steel window sashes, permanently fixed in place so that the windows cannot be opened, constitute an innovation in that they will be equipped with two thicknesses of glass with an air space between. The inside pane will be standard window glass while a patented heat absorbing glass will be used as an outside protection. If window openings must be provided, long experience has demonstrated that satisfactory low summer temperatures within the building require the use of special glass that will impede the transmission of heat rays.

Ten Changes of Air an Hour

Despite steel-clad insulation for exterior walls and roof, and heat absorbing window glass, no clinic or hospital can be considered modern without a fully automatic system of air conditioning. In the case of patients with arthritis, fresh, filtered air tempered to summer and winter conditions is essential, and great precautions must also be taken to keep the humidity low. A system was therefore installed that will ensure ten complete changes an hour of air that is clean, fresh and dry. In summer it will be cool and in winter warm, but at no time will its humidity be greater than that of the atmosphere outside the building.

Floor plans of the clinic are characterized by a minimum of waste space and feature an arrangement of executive, medical, laboratory and treatment facilities that will further a maximum of efficiency and economy from the viewpoint of service.

Since the laboratory plan in The Wyatt Clinic possesses certain features that may well be of great

The Wyatt Clinic was built to withstand the high atmospheric temperatures of summer. Steel-clad insulation was used for exterior walls and roof, while window glass is heat absorbing. An automatic air conditioning system ensures the building ten complete changes an hour of clean, fresh, dry air

value in the planning of the laboratory in small hospitals, special mention of it will be made.

The floor plan is based upon the principle of the dining car kitchen. Every available inch of space is utilized to the greatest possible extent for efficiency and convenience. Ventilation is so arranged that laboratory workers as well as persons in other parts of the building are in no way disturbed by the unavoidable odors and excessive elevations of temperature that occur in the laboratory.

Unnecessary to Enter Laboratory for Specimens

The office provides not only locker, desk, library and study space for the director but also an accessory room to the medical offices. Suitable table and other facilities are provided in this room so that all necessary laboratory specimens may be readily obtained from patients without the necessity of having them enter a room in which active technical work is being carried on. File cases built into this room assure the permanence and availability of the laboratory duplicate records required by the American College of Surgeons.

The main diagnostic room is equipped with the usual work desk, drawer and cupboard space, separate soapstone sink with drain board, refrigerator and other items. Its main feature is a low solid two-person microscope table, 42 inches long and 24 inches wide, equipped with a water tap, gas and electricity. This table faces a narrow wall cupboard with glass panel sliding doors. The shelving in this cupboard is so arranged that either worker, once seated before his microscope, may reach without moving from his stool every reagent, dye, slide or other piece of apparatus he may need to complete the preparation and microscopic examination of any ordinary specimen in clinical laboratory microscopy. His use of this material is further facilitated by a small drained well, built into the table top. This well with its removable bars over the

top accommodates almost every staining procedure.

A wall-fixed typewriter shelf near-by suggests the immediate completion of the microscopic examination to its final typewritten form.

The utility room with its U-shaped sink and drain boards, sterilizing equipment, storage space and work desk makes adequate provision for all cleaning and other preparation work. A strong forced vent in the ceiling ventilates the entire division without permitting in any way the recirculation of air from the laboratory to the remainder of the building. Since the utility room is the source of the worst odors, the location of the central laboratory ventilation in this room with one-way currents into it from all other laboratory rooms makes the control of odors doubly certain.

Room Designed for Antigen Production

The research room is notable in its location chiefly for its isolation. In conformity with federal public health service requirements, it is completely shut off from all routine work and is equipped and designed solely for the specific purpose of antigen production under United States Government License No. 112. In ordinary hospital planning, this room would be an ideal bacteriologic and serologic laboratory.

Viewed as a whole with its thoughtful lighting and work desk placements, the great utility of this administrative, diagnostic and research laboratory unit is further notable for the fact that it is com-

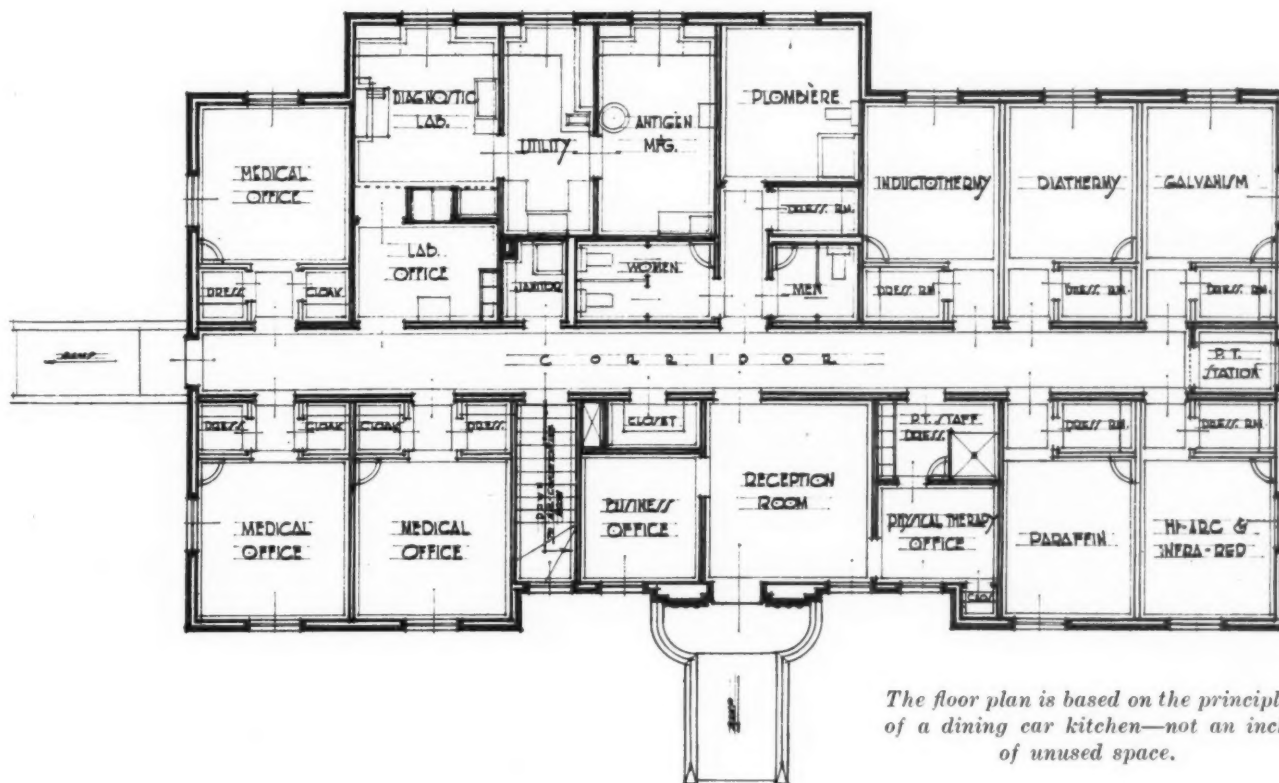
passed in an amazingly small total floor space.

Eight persons make up the staff of The Wyatt Clinic and Research Laboratories — three physicians, an executive secretary, two registered nurses and two laboratory technicians. This initial unit of the foundation represents an investment of \$53,000.

COMMENTS OF CRITICS

DR. B. C. MACLEAN, superintendent, Tuoro Infirmary, New Orleans, who was asked to comment on the plans, replies as follows:

"The hospital is an ideal proving ground for experimentation in the field of air conditioning because of the additional therapeutic possibilities it provides. The lowered temperature that it brings is an important factor in the treatment of enteric disorders of children; the constant temperature that it affords is of great assistance in the evaluation of vascular disorders and, of course, for the allergic diseases, such as asthma and hay-fever, it is of tremendous benefit. The humidity control thus achieved is often even more important than lowered temperatures in the operation of such installations. Undoubtedly, the hospital of tomorrow will be both air conditioned and sound conditioned. The former presupposes the latter insofar as outside noise is concerned and the increasing use of sound absorptive materials in hospital construction promises an escape from the noise nuisance, long the bugbear of many institutions.



The floor plan is based on the principle of a dining car kitchen—not an inch of unused space.

"The simple but effective architectural design, the efficient layout and the constructional innovations of The Wyatt Clinic deserve more than ordinary interest, and it is unfortunate that the article does not include more specific information regarding unit cost and more detailed explanation of the type of air conditioning apparatus installed. Hospital administrators are eager to learn more of the comparative merits of decentralized compressor units and centralized duct installations.

"The former lend themselves readily for experiment in individual hospital rooms but it is probable that, as in The Wyatt Clinic, the centralized air cooling and air filtering or washing system will be the approved installation of the future."

A Consultant's Evaluation

CHARLES F. NEERGAARD, hospital consultant, New York City, has reviewed the article and floor plans, and his evaluation follows:

"It is always stimulating to read the description of a new hospital building wherein those responsible for its planning have applied the results of new architectural and engineering knowledge and research. Too often the hospital suffers from innovations that are not compatible with economy, but such a feature as proper insulation will save its cost many times over during the life of a building by the resulting reduction in fuel consumption and the increased comfort.

"The structural experiments, if they may be so called, in the Tucson clinic, in other moister and more variable climates might forecast trouble. Steel facings are susceptible to rust, and the dead air space, unless effectively dead to all air circulation may prove ineffective insulation and cause difficulties from condensation. The double pane window with an outer sheet of heat repelling glass sounds most effective.

"The statement that 'no clinic or hospital can be considered modern without a fully automatic system of air conditioning' may perhaps be questioned. It has been said that 'no new thing arrives without a certificate of necessity in its hand.' The advantages of air conditioning cannot be gainsaid and certainly skillful advertising is rapidly succeeding in creating a public demand for it. During the depression, however, the hospital has learned the value of the dollar and will move with conservatism in accepting as a fundamental of modernity any new feature that involves so large an initial investment and so much in depreciation and operating expense as general air conditioning.

"The arrangement of the clinic appears compact and adequate and should afford excellent facilities for the study and treatment of arthritis.

"The director and architect are to be compli-

mented on their pioneering spirit. They will confer a marked benefit on the hospital field if after two or three years in their new building they report frankly and in detail what it costs to operate the air conditioning machinery and how well the innovations have worked."

The Authors' Reply

AFTER reading the comments of Doctor MacLean and Mr. Neergaard, Doctor Wyatt and Mr. King write as follows:

"The director and architect are most appreciative of the comments by Doctor MacLean and Mr. Neergaard and are in thorough agreement with the remarks of the former regarding the future of air conditioning in this country. As Mr. Neergaard suggests, we may have been too inclusive in our statement regarding the necessity of air conditioning for all clinics and hospitals, but for those in desert climates the 'certificate of necessity' is not open to serious question.

"The air conditioning installation selected embodies the following features: natural principle air cooling, dust and pollen filters, slow speed blowers, high transfer cooling radiators, frictionless flow, silent electric motors and low operating costs.

"Despite the large amount of electrical, plumbing and other installations, the construction costs of the building are only \$1 per cubic foot.

"The factor of rust is by no means negligible even for the Tucson area, but it is believed that the modern treatment of steel facings will reduce deterioration from this cause even in districts with much greater humidity values.

"Not only will a frank report and cost record be presented at the expiration of a year (if desired), but also, in connection with the second unit that is to be erected at an early date any changes in construction methods and materials that are deemed advisable or necessary will be carried out and the reasons therefore made available to the readers of *The MODERN HOSPITAL*.

Aid in Textile Buying

Actual specifications used in buying sheets, pillow cases, wool blankets, cotton blankets, wash cloths and bath towels at the King County Hospital System, Seattle, are presented in print in the 1934 edition of *The HOSPITAL YEARBOOK* soon to be off the press.

These specifications are based on laboratory tests, answers to questionnaires received from forty-seven leading hospitals of the United States and Canada, federal specifications and the local requirements of the hospital for which they were designed. Grace G. Denny, associate professor of home economics, University of Washington, and Mary W. Northrop, chief dietitian and housekeeper, King County Hospital System, are the authors.

Distinguished Service in the Hospital —A Stimulus to Progress

By OTHO F. BALL, M.D.

Chicago

IT MAY be that the character of service rendered in hospitals will not change as greatly in the next ten or twenty years as it has in the last ten or twenty. Improvements of plant, perfection of the machines of medical science, the organization of men and materials to combat disease on wide fronts, and, particularly the betterment of medicine and methods for treatment of the sick and diseased individual — in all these things we may have changed and progressed more in times past than we shall in corresponding times to come. But this is extremely unlikely and probably no reader will take any stock in suppositions such as these.

If, however, methods and the character of service dispensed in hospitals do not change much, at least the environment in which present methods are used and the needs of the sick will change greatly. Economic conditions have changed, are changing fast. Social conditions, the environs in which a hospital works, are changing faster. One need not be an apostle of change or even progress to observe that. The indomitable and remorseless part of change is that it takes place around us while we gather quorums to debate desperately whether it should take place and whether we will change with it.

By surveying the past and looking forward, what can be predicted about the nature of the changes which await us or which we will make? It seems that there is much to indicate that they should represent more largely improvement in quality and comprehension of work done than increase in quantity of work done or further mechanization of it.

Medicines, machines, material facilities and routines have improved marvelously during the last twenty years. But in our justified zeal to improve them, we may have been diverted somewhat from questions of method, personnel, the

fundamental human relations and qualitative service. The sharp and intense focus upon technicalities, which has been so necessary to achieve the progress made, may have narrowed our view. On the side of materials and machines creditable work has been done. But labors in this direction are somewhat curtailed now. Is not this, then, an opportune time to turn attention to ways and means of obtaining better results from the materials and machines we have, to study more extensively their effectiveness in terms of human service and their significance in terms of human relations?

It would seem profitable, at this time, to provoke discussions and encourage speculation regarding the wider aspects and the future of hospitalization, personal and personnel relations, community relations and what can be done to improve the personal quality of service even though its quantity may not be greatly increased. It is with this thought in mind that many men are asking questions and debating matters that might not have been so appropriate a few years ago. Some of these thoughts may be of immediate interest to the whole field.

To begin with the innermost part of a hospital and work out, it might be well first to scrutinize the very foundation of the hospital, its chartered existence and control. Frequently a hospital that came into being with a charter completely adequate to effective operation at the time it was granted, now finds the charter so antiquated or the environment of the hospital so radically changed that the

"A hospital may be a distinguished institution, no matter what its size. If it is great in spirit, original in its outlook, creative in its service and inspiring in its community relationships, it will assume a definite personality. Distinctive personal character compels interest, commands respect and augments support. It is the most potent force in attracting and holding friends for the hospital and a true stimulant to progress"

original charter and the type of organization structure it dictated are a decided handicap to wholesome development of the hospital.

In their beginning, most hospitals were incidental adjuncts of other social or industrial groups. Many of them were established as missionary adjuncts of some religious organization. Others came into being to serve the private needs of a group of clinicians. Some were organized to take care of the casualties of industry. Fraternal organizations founded hospitals to care for the needs of their own membership. Others were just unimportant parts of a medical school and today still others have been completely submerged in the clinical work of large medical centers with which they have recently become associated. It is not surprising, therefore, that the charters of some hospitals provide an inadequate foundation upon which to base a rational development meeting present day needs.

Management in Absentia

A good example of the anomalies of existence and of the obstacles to wholesome development sometimes encountered by a hospital is provided in the situation of one of the most modern hospitals in the Midwest. It was founded, organized and chartered by a small religious group which has since removed ninety miles from the city in which the hospital is situated. This group still owns the hospital and, according to the charter, has full and sole authority to manage it, yet it has been necessary to shift the responsibility for management, by one legal trick and another, to a local board of so-called visitors. The whole system from beginning to end is cumbersome and full of red tape and, needless to say, is not in any sense conducive to effective and efficient management. That this hospital is well managed despite its handicaps is the finest possible tribute to the devotion of those interested in it.

Under ordinary circumstances the typical hospital can only do its best work when it holds as its primary motive the efficient care of the sick, reducing other activities to adjunctive positions, and when its management is close, direct and well centralized.

As we explore the hospital's relation with its community further, we may well ask if its self-perpetuating board is composed of virile, active men with broad and constructive vision who are representative of the best obtainable in civic leadership. Dr. Charles H. Young, director, Mountain-side Hospital, Montclair, N. J., succinctly analyzes this question when he says, "The founders of the hospital and the boards of its early development may have been the best the community afforded, they may have established fine traditions of service

and pointed the way of their perpetuation, but as time goes on their successors may fail to interpret the spirit or live up to the established principles."

He goes on to point out that all too often membership on the board becomes a social asset and an opportunity for self-aggrandizement. New members are chosen from relatives and friends, the socially eminent and the wealthy and influential, regardless of ability to direct the destinies of the hospital. Unfortunately, these persons sometimes serve on the board from maturity to senility never giving way to others better fitted to guide and counsel in the management and development of the hospital.

The best talent of the city's citizenry is not made available on the governing board, and if it is not, "the best hospital service is not attained" for the community. He concludes that what is true of the self-perpetuating board of trustees is quite true of the self-perpetuating medical staff. The faults and weakness of the one are just as likely as not to be the faults and weakness of the other.

To move on a step, questions of personal fitness in executive and administrative set-up of a modern hospital cannot be introduced without discussing the hospital superintendent and his assistants on the management staff. No hospital can give truly great service unless the superintendent and his assistants are trained and able, on broad scales, (1) to analyze the particular needs of the service area, (2) to inventory properly the capacity of the hospital to meet those needs, and then (3) to adjust and organize the hospital to supply the community up to the fullest measure of the hospital's capacity. Here again capabilities, personalities and personnel relations are as important as wealth, plant and material facilities.

Hospital Service Requires Executive Fitness

In the past, hospitals as a general rule have not had any fixed policies that made executive training, fitness and capability requirements in the employment of administrators. Can it not be admitted candidly, one correspondent asks, that there are still far too many hospital superintendents who could neither by training nor experience qualify to run any other activity combining business, professional and public service of a scale equal to that of the hospital? Yet without the utmost in executive fitness we cannot expect the breadth of view, comprehension and organization ability that alone can account for distinction in service in a hospital whether or not it is wealthy, well equipped or highly standardized. Otherwise a hospital runs along in a mechanized routine that eventually becomes a rut.

Dr. B. W. Black, medical director, Highland Hos-

pital, Oakland, Calif., believes we can expect no individualism, new and constructive plans or departure from precedent as long as a man of no more than average competence heads a hospital. Under the duress of present financial conditions, this question is becoming acute in many hospitals. Mediocrity may go unjudged in prosperous years but lean years almost always expose it. He believes that a lesson is being learned — that the future will bring about a favorable change in methods of selecting hospital executives as well as a demand for more sufficient training and experience.

It Is Character That Counts

Grandeur of architecture and high standard ratings can never produce distinctive service. Nor can they substitute for capability, personality and the genius for splendid service. In his Ether Day address at Massachusetts General Hospital in 1921, Dr. Harvey Cushing discussed these human attributes with the charm for which he is noted. "Raiment counts for little and the humblest may cover a personality capable of permanently influencing the motives, the ideals and the actions of countless others. . . . So it is not the externals or the inherited wealth, social position or occupation of an institution any more than an individual which give it renown, it is the character of the service it performs — the quality more than the quantity of its work which enables it to establish and to maintain leadership."

We have reached a point in the development of hospitals in America at which it is, I believe, important to discuss critically the values of standardization. It goes almost without saying that until a hospital has learned how to live up in the fullest practical measure to the potentialities of its material resources and personnel, standardization at high levels pointing toward high material efficiency is of greatest importance. However, in the development of a hospital it should never be forgotten that standardization exists only for the purpose of bringing many hospitals up to practical *minimums* of efficiency and effectiveness.

Once that point is reached in the development of a hospital, standardization can give us no further impetus to progress above the highest possible *average*. Beyond that point standardization is sterilization — it is as likely to inhibit progress and development as it is to promote them.

It seems fair to conclude therefore that standardization at any tentative level should mark an epoch in hospital progress and development. Beyond that epoch in hospital development, only systematic differentiation or diversification of ideas of development seem to hold any hope of progress. Thus, beyond certain points, experimentation

seems as necessary to progress in hospitalization as it is to progress in the exact sciences, and out of experimentation will come new and higher levels of standardization. Standardization must not be static. It should be progressive. This was the original concept and is, I am sure, the abiding view of all those who direct standardization movements today.

This statement probably will not and certainly should not be interpreted to mean that most hospitals have achieved a position so advanced that campaigns for standardization, such as that waged so diligently by the American College of Surgeons, no longer offer them hope of progress. Most hospitals have not achieved the utmost that meeting present standards alone can help them achieve. Many hospitals have not even made a fair start in that direction and until they have they should not occupy themselves with far flung dreams of future conquest.

On this score, however, mere statement of another fact may serve as a warning, the substance of which is so aptly phrased by Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, when he says that efficiency and standardization programs are likely to have much in them of the competitive endeavor of "keeping up with the Joneses." This endeavor should never become an end in itself. A sympathetic understanding of the needs of our patients, needs both of hospital service and things beyond hospital service, should be our ultimate objective.

An Imperative Warning

While discussing the benefits and limitations of standardization, one other warning is imperative. It is for those who would abandon standardization too quickly. Change in method and concept may be constant and inevitable. But desire for change — change for the sake of change — is even more constant in the minds of those who fail in their use of standard procedures. When it is suggested that hospitals turn to systematic diversification of procedures after standardization has accomplished the progress it can, there will be those who find the suggestion irresistible, who will gladly fling themselves into it before the full benefits of standardization are realized.

In seeking to develop rational individualism and to perform distinctive service it is easy to confuse distinction with sheer difference or even eccentricity. Unique service is not necessarily distinctive service. Change for the sake of change, difference as an end in itself, these are shallow abominations. It is sometimes discouraging to realize how much of so-called distinctive and individual hospital service is little more than cultivated self-consciousness,

aggravated eccentricity calculated to gain notice, stunt publicity.

As Dr. Basil C. MacLean, superintendent, Touro Infirmary, New Orleans, points out, "The much vaunted institutional personality or atmosphere is sometimes genuine and unaffected but often it is of the luncheon club variety." He cautions that, "Pericles was a period but Greece was an age." And he concludes that, "Active participation of a hospital head in a diphtheria immunization campaign or other public health project will win more friends for his hospital than membership in a golf club."

If distinctive service, highly personalized, and courageous experimentation are essential to more than average progress, and yet if attempts at these frequently develop the rather ridiculous characteristics of begging for popular attention, the question naturally arises as to what one or several formulas may be used successfully to avoid these bad results of good intentions.

Formula for Individualism

Dr. S. S. Goldwater, who is now engaged in the difficult task of integrating the hospital service of our greatest metropolitan area, has offered suggestions which, to my mind, might rightfully be accepted as the formula. Certainly the chances of failure are greatly minimized when these suggestions are followed. He prefaces them by saying that a distinctive reputation for a hospital can be built by sufficient accentuation of any service proper in a hospital but that arbitrary pursuit of distinction or reputation along these lines probably does not hold the greatest promise of success.

He believes that success in the attainment of true caste or individualism in a hospital is more likely to be achieved where the hospital has the good fortune to find in its organization an individual or group with special talent for a particular kind of work and then lends encouragement to the individual or group to exercise imagination to the fullest extent, thus affording the talent free outlet for expression and development. He reflects that hospital departments and services that have become truly famous are almost invariably associated with outstanding genius or talent of a special sort.

But genius is rare. Can close cooperation and the proper organization of the best talent we have produce the results of individual genius? If it can, Doctor Goldwater's suggestions might be reduced to some such formula as the following: (1) Service of any kind does not attain distinction unless there is a public need of it. Consequently uncovering the special needs of our community and clearly defining them is the first step. (2) We must appraise our material facilities and the talents of our staff to

find which of these special needs of the community we can best fulfill. (3) Work decided upon must be started on at least a small scale. (4) Persistence must be shown in seeking support for the work.

The first two steps in this procedure, namely, the appraisal of the community's special needs and the hospital's ability to fill them, may be interpreted as rigorously and gone into as far as inclinations and resources carry, but no hospital can back away from an attempt to experiment with its opportunities for distinctive service on the excuse that it has no resources to make a scientific canvass of the special needs of its community. Too many opportunities are to be found in almost any community.

In discussing, through correspondence, these opportunities for distinctive service quite a few men residing in different sections of the country made similar statements, which seems to me to indicate a widespread need for the services they urge. A number of men, notably Dr. Michael M. Davis of the Rosenwald Fund; Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., and Dr. W. S. Rankin of the Duke Endowment, suggested various forms of cooperation by the hospital with local public health and social service agencies.

Doctor Davis suggests that the hospital in many instances might "furnish headquarters for the office of the local Visiting Nurse Association if the hospital is centrally located, or for a branch office if in an outlying district." He suggests further that space might be provided by the hospital, with or without rental, in which physicians of the regular or courtesy staff could hold office hours or maintain their regular offices for seeing private patients, thus making the hospital the real medical center of its community. He also advises cooperation with local industries in providing medical and health services supplementing those furnished by the industry in its own plant.

Teaming Up With Welfare Agencies

Doctor Munger elaborates on the possibilities of connection with the Visiting Nurse Association. He tells of one hospital which took upon itself the unusual function of running the association and completely coordinated it with the out-patient department of the hospital. He suggests that many of the essential functions of local social welfare agencies might likewise be coordinated with the hospital's out-patient department. He urges the closest cooperation with local medical associations.

Doctor Rankin believes there are many possibilities of connection between hospitals in the smaller communities and county health work and he cites the case of Dr. J. Moss Beeler, superintendent, Spartanburg General Hospital, Spartanburg, S. C.,

who also has charge of public health work in Spartanburg County. Doctor Beeler has harmoniously coordinated pretty nearly all the curative and preventive activities of medicine in his county.

As a matter of fact, even a superficial survey of the possibilities of the average hospital rendering distinct and individual service which would build the friendliest possible relations between the hospital and its community would show the opportunities to be legion.

Then there are certain problems in the field of public health and hospitalization that all hospitals should be thinking about—perhaps even studying cooperatively right now. One, for instance, is involved in the shift in population and population trends that are resulting from the economic and industrial readjustments that have taken place and are taking place in our financial depression and recovery—trends that are influenced also by lessened birth rate and reduced immigration. These readjustments may leave certain hitherto sparsely populated sections of the country even more woefully underhospitalized than they are now, while hospitals in densely populated metropolitan areas may have to think more than ever of occupancy and use of capital investment. However, problems such as these should not receive the best thought and attention of the individual hospital administrator as long as there are so many other problems nearer home which are crying out for immediate solution.

Aside from factors extraneous to the hospital field, there is in the making an influence that may have far-reaching effects on the division of labor among institutions for the sick in our larger communities. This is the organization of hospital councils which is being fostered by the American Hospital Association.

When men with common interests gather together, it is not long before specialization of effort is a natural result. Will the closer integration of

the hospitals of a city having several institutions follow this normal procedure? It would seem that such a result is inevitable since the dominant interest is improved service to all of the community rather than the selfish and competitive ambition of a minority of trustees, staff, administration or public.

Dr. Willard C. Rappleye, dean, Columbia University College of Physicians and Surgeons, in a recent letter states, "The great need in the hospital field seems to me to be the necessity of articulating

the problems of several hospitals in each community where more than one exists into a common enterprise. There are altogether too much of the competitive and too little of the cooperative spirit, which have undoubtedly resulted in the building of unnecessary institutions in varying levels of excellence."

Lastly, we should not forget a thought that Dr. Joseph Brennemann of the Children's Memorial Hospital, Chicago, expresses so well when he says, "After an extended experience with a dozen widely differing hospitals, as intern, attending physician, visitor and patient, my attitude toward a given hospital centers in the emotions, in the heart, rather than in the mind, and I believe that reaction is freely shared by others. It is the atmosphere, the morale of a hospital, that makes or wrecks its reputation and its usefulness

to the community in which it is located."

In the end, a hospital may be a distinguished institution, no matter what its size. If it is great in spirit, original in its outlook, creative in its service and inspiring in its community relationships, it will assume a definite personality.

Distinctive personal character on the part of an institution compels interest, commands respect and augments support. It is the most potent force in attracting and holding friends for the hospital and is a true and effective stimulant to progress.

To reawaken public support it will be necessary first to bring back public interest and attention. The surest and soundest way for hospitals to do this is to publicize their recognition of the new needs which have developed. Obviously the typical hospital must devote most of its effort to absolutely essential routine services. But it is the extra-routine or marginal activities that differentiate from the fixed pattern and make for distinction and progress. May not the greatest opportunity of arousing favorable public interest be found in devising distinctive and outstanding services for its community? The Editors invite your comment on this subject



This former residence is now a 12-bed hospital.

In Eaton County They Call It

In that little hospital which humble folk maintain,
He'll find that hearts are merciful and quick to
comfort pain.

IN PENNING his ode to the small country hospital, Edgar Guest may or may not have had occasion to visit Charlotte, Mich., and Hayes-Green Memorial Hospital. Even if he had, the chances are he would not have recognized it as a country hospital, so imposingly does it stand among stately lawns and picturesque gardens. Once inside, however, he would have found all the atmosphere he so affectingly describes. His talks, too, with the residents of Eaton County would have revealed ample evidence of the pride of the "humble folk" in "our hospital."

Hayes-Green Memorial is "our hospital" to all of Eaton County, not so much because it is owned by the county but because it is part of the county, having been at one time the residence of a prominent citizen. A homelike atmosphere surrounds it, minimizing hospital air at no sacrifice to service.

Many residents recall the time when an eccentric, yet remarkable musician lived there and taught music to many residents in the community. Through his entire life this man had entertained elaborate plans for his home but because of lack of means, he never completed more than the exterior. After his death, his residence became the property of Henry Hayes and R. Ellen Green, whose ambition it was to have it developed into a modern hospital to care for the sick of Eaton County. At Mr. Hayes' death, therefore, Miss Green gave the spacious estate to the county with sufficient funds to transform it into a thoroughly up-to-date institution.

No vast medical center could hope to present a more stately, dignified appearance than does this country hospital. Constructed of hand chiseled stone, the gray effect of which is softened by green vines, the building stands on a beautiful knoll from which a terraced lawn slopes gradually down to the street. Great oaks stretch their massive limbs

Michigan, with Charlotte as our particular objective, comprises this month's Little Journey where an inspection of Hayes-Green Memorial Hospital reveals what a modern twelve-bed unit can mean to the community. This hospital is county owned, and interest in its support and maintenance is shared by the citizenry

By RAYMOND P. SLOAN

Associate Editor, The MODERN HOSPITAL



Little patients and adult, medical and surgical cases, all are cared for here.

It "Our Hospital"

upward and a rock garden to the east provides the effect of a sunken garden, marking the beginning of a landscaping project to be completed later.

Twelve beds and five bassinets comprise the hospital's entire capacity. Yet it is equipped so that no one need travel elsewhere for care! The patient brings his surgeon to Charlotte, where he can be near home, family and friends.

Some idea of the extent of the territory that the hospital serves may be gained from the population figures of Eaton County which total 31,728. The county covers twenty-four square miles and is divided into sixteen townships, each covering an area of six square miles. While the county cannot boast any large cities of its own, Lansing is only eighteen miles distant and Battle Creek is thirty miles away. Hence a great many of the more difficult operations that take place in the hospital are performed by surgeons brought in by the attending physicians.

Obviously, much renovation had to be done

when the building first became a hospital. The approximate cost of this work, including furnishings, involved \$24,434.41. In addition to this, about \$6,884.50 worth of equipment was donated,

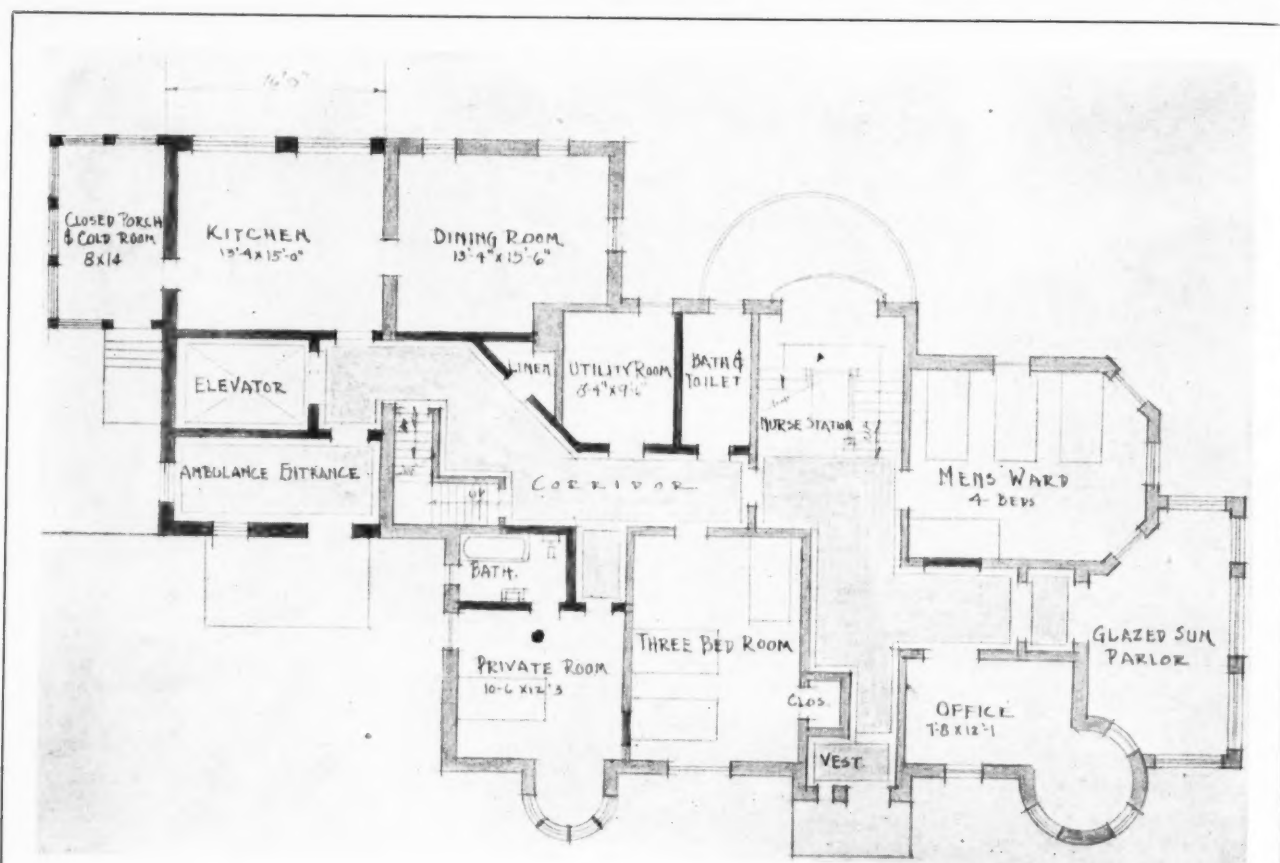
including facilities for x-ray examinations.

The interior, for example, was completely refurnished with new plastering, some new woodwork, all new hardware, flooring and lighting. Floors were treated successfully with two layers of wood covered with felt and asphalt tile on the surface.

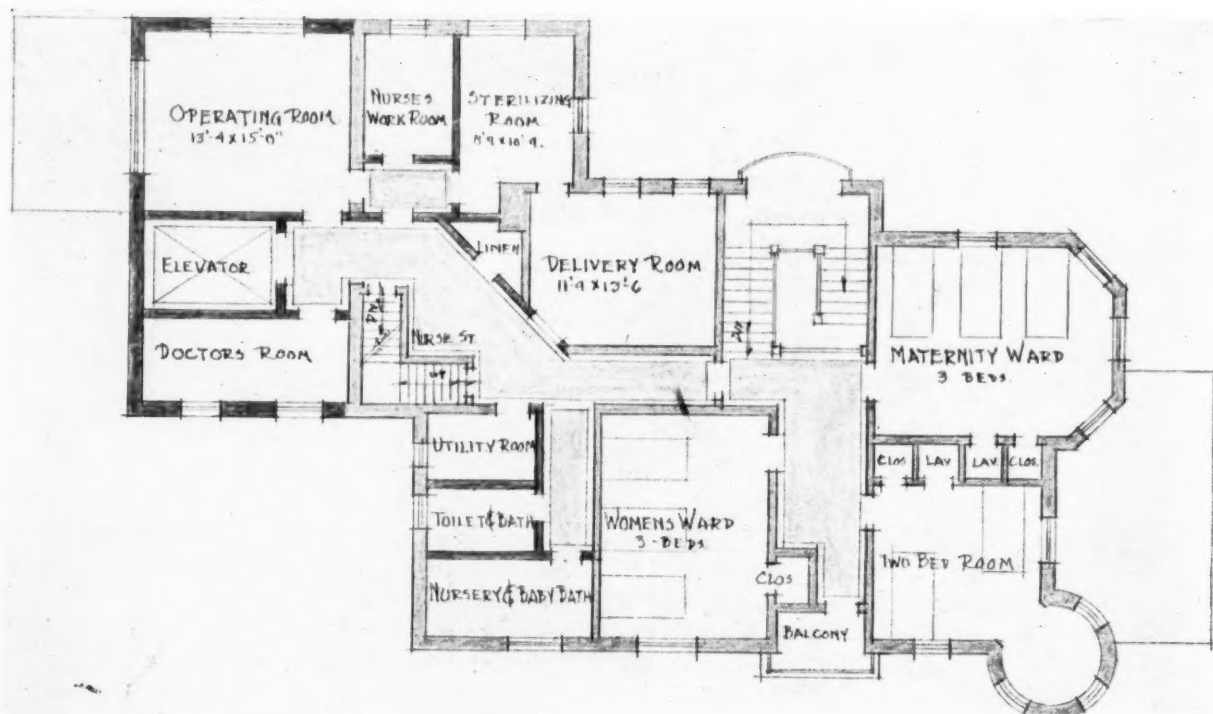
Hall floors were finished in buff and green with black borders, while those in the rooms are buff and brown bordered with black. In harmony with this color scheme, the walls are a light, soft ivory, the woodwork is a darker ivory and the doors have their original dark oak finish.

Great care was exercised in selecting the furnishings and equipment so that every detail might be in keeping with the homelike atmosphere of the building. Wooden beds were chosen with bedside chairs and tables finished in dark walnut. Beds were equipped with three-inch rubber casters with extension rods, crank springs and the best cotton felt mattresses it was possible to purchase.

The surgical unit was carried out in a soft green.



The first floor plan of Hayes-Green Memorial Hospital. The darker gray walls show new construction and the lighter gray, the old building. The shaded sections in the middle are corridors.



The second floor plan shows operating and delivery rooms and women's and maternity wards.

This comprises the operating room, dressing storage, sterilizing and scrub room and delivery room. The operating room was fully equipped, and the delivery room, while simple in furnishings, was made efficient for the doctor and as comfortable as possible for the patient. Because of the size of the hospital, a call system was arranged in the delivery room and, if necessary, this room can be used as a case room. Across the hall from the surgery, a doctors' lounge was installed, equipped with lockers, a comfortable davenport and chairs. The nursery, comprising five bassinets, boasts today a respirator and all modern equipment.

Elevator Had to Be Installed

The installation of an elevator was included in the renovation program. The elevator serves three floors—basement, first and second. In the basement a modern x-ray department was established. Here, too, was set up an emergency room and laboratory. In the laboratory are conducted all necessary tests but no culture or pathological work is performed since this is all sent to a pathologist in Lansing.

It was decided that steam would be most practical as a heating system with a stoker installed, thus eliminating a night fireman and allowing the janitor to assume other duties. This stoker system has been found satisfactory in maintaining an even heat, and it is more economical to run than to hand

fire and pay the salary of an extra man. It is possible also to use a cheaper grade of coal in the stoker.

It is interesting to note the personnel required in running an institution of this size. In addition to Florence A. Tunison, R.N., superintendent, the staff consists of three graduate nurses. One of these is entirely responsible for the surgical unit and acts as doctors' assistant in all surgical and obstetrical cases. One nurse is on general hall duty with a relief nurse supplied when necessary. The third nurse does night duty in the building, calling for relief when necessary. In addition to her post as superintendent, Miss Tunison has charge of all x-ray and laboratory work and, in general, covers all departments from the furnace room to the attic. Additional members of her organization are a capable cook and a maid who alternate their time off, as well as a janitor and a full-time bookkeeper.

No Physicians Serve on Board

Like other and bigger institutions, the hospital has its board of trustees composed of seven members, all of them business men chosen by the board of supervisors of Eaton County. Three of the seven are also supervisors. Doctors have been deliberately eliminated from the board because of the fear that this might create a certain amount of jealousy among the other men since Eaton County has general practitioners only and no specialists.



Soft green walls appear in the surgical unit, the operating room of which is shown in this photograph.



Wooden beds help to give the patients' rooms an atmosphere of home.

That the hospital is not only owned by the county but is part of it is revealed in the activity of its various guilds. A women's auxiliary was organized with one county president, three vice presidents, a secretary and treasurer. A hospital guild, in turn, was organized in each one of the townships and in each ward in Charlotte, each guild being responsible for certain furnishings. To this auxiliary goes credit for much of the success of the building, for through its persistent efforts is supplied all the linen for the beds, patients, operating room and delivery room, as well as silver, dishes, pillows, curtains and practically all the canned fruits, jellies, jams and vegetables used in the hospital. Each guild is responsible for so much, and this responsibility is permanent. One, for example, looks after the nursery, another supplies the bed linen, another the curtains, and so on. They have not only established a stock of linens and other supplies but have retained the upkeep of each department, replacing it from time to time as the need arises. This organization is complete and efficient and has created an unbelievable amount of interest in the hospital throughout the county.

Guilds and Clubs Give Lavishly

Each guild has a different method of obtaining money. Some of them have bridge benefits and entertainments. The business women's guild in Charlotte, for example, collects ten cents from each member at every meeting, since these women are all employed and do not have time to obtain money

in other ways. Among its other services, the business women's guild provides favors for the trays for each holiday.

It is not alone from its guilds, however, that the hospital receives support. Other clubs in the community contribute to its maintenance. The women's club, for example, was instrumental in helping to provide an incubator for the nursery. In fact, every organization has done something toward maintaining the institution. Sunday school classes in the town have furnished Bibles for each room.

Business men have supplied stationery. Shoe merchants have given bedroom slippers for indigent patients, and individuals have donated bathrobes for their use. Other individuals and organizations have assumed the responsibility of seeing that each patient has flowers some time during his stay in the hospital.

"The fact that the hospital is county owned," Miss Tunison explains, "and Eaton County boasts of farm lands and taxpaying citizens, makes it easier to grasp the enthusiasm shown in making the institution self-supporting if possible. So far it has fallen but a trifle short of its goal."

This enthusiasm on the part of the citizenry is the result, too, of the interest which the hospital in turn has shown in each patient. To quote again from Mr. Guest:

And whoso'er shall tread the hall when you are
free from pain,
Will stop to speak a cheery word and wish you
well again.

More Hospitals Adopt Eight-Hour Day

Thirty-two hospitals in New York City have now adopted the eight-hour day for nurses on private duty, among those recently following this policy being the Post-Graduate Hospital and the Knickerbocker Hospital. The latter institution is providing this eight-hour service on an optional basis whenever both physician and patient desire it.

Is Compulsory Health Insurance Desirable?

By W. R. CHENOWETH

Superintendent, Royal Victoria Hospital, Montreal, Canada

HOSPITALS that are alive to their responsibilities must face and seek answers to two problems: (1) To what extent is better or more adequate medical care needed by the people? and (2) Is there any practical method or plan to supply all the people's needs with good medical service?

Now in dealing with the first aspect of this matter I presume the result of the investigations of the Committee on the Costs of Medical Care might be accepted as our guide, and in perusing its report we are informed that:

"The amount of care which people need is far greater than that which they are aware of needing, and greater than that for which they are able to pay under present conditions.

"In spite of the large volume of free work done by the hospitals, health departments and individuals, each year nearly one-half of the individuals in the lower income group receive no professional medical attention of any kind—curative or preventive.

"Our present system, on the one hand, lays an unjustifiable burden of unpaid service upon the physician and the hospital and, on the other hand, frequently gives the individual of the middle economic level only a choice between becoming a recipient of charity or foregoing medical care that may be much needed."

The Burden Grows

This in a nutshell is the challenge that confronts the hospital field in America today. It must be met because our hospitals are groaning under the burden of their debts and yearly make sorry appeals for larger allowances before perplexed county, municipal and state authorities, while a large number of the medical fraternity are hard pressed to make both ends meet.

In more recent times hospital administrators have followed with interest the inauguration of such schemes as group insurance, periodic payment plans, flat rates, pavilions for patients of moderate means, and finance corporations for financing medical care. In my opinion these are palliative meas-

ures at the best and do not strike at the root of our troubles in providing adequate health service.

There are those who advocate state medicine as a solution of our difficulties. In considering such a proposal, one may rightly ask to what extent or in how large a measure shall the state enter into and control human living? How far is the standardized and state controlled condition of affairs best for the people in matters relating to hygienic conditions and the whole embracing problem of health? We all know that when the state steps in voluntary action and individual effort step out, a reaction that must be viewed with concern.

A Tribute to Voluntary Hospitals

A casual glance over the past records of our institutions reveals that their pages furnish an illustrious tribute to those who by voluntary effort, self-sacrifice and generous financial support have succeeded in placing our privately owned institutions in the eminent place they occupy in the medical world today. It may be true that in certain phases state control is admissible, for example, for mental institutions and homes for incurables, but the field of preventive and curative medicine, I contend, is a responsibility that vitally concerns every citizen in terms of money and of personal interest.

It is important to note that in dealing with the incomes of families in the United States the Committee on the Costs of Medical Care presented the following findings:

"In the first place, incomes in the United States are so distributed that relatively few families have an income as large as the arithmetic average. Approximately 50 per cent of all families of two or more had during 1928 total annual incomes of less than \$2,000 and 40 per cent more had incomes of \$2,000 to \$5,000. Our estimate of the distribution of individual income recipients in 1928 indicates that 80 per cent of them had incomes of less than \$2,000 and 95 per cent of less than \$3,000."

It is these people who demand our attention today.

Therefore, from the standpoint of the institu-

tions engaged in the treatment of the sick, the question we must ask ourselves is, can we reduce the expense of medical care so that our charges will be within the financial reach of these people, and at the same time allow them to pay a reasonable fee to the practitioner who today receives little or nothing for the service he renders to these patients? In the light of prevailing conditions and the standard of efficient service that must be maintained to produce the best results, I, as a hospital administrator, cannot conceive for the future any radical downward trend from present day costs of medical care. So we must look for and devise other means of solving our problems.

Now whether we like it or not we cannot get away from the fact that we are to a certain extent our brother's keeper. The health of a particular person or community can no longer be treated as an isolated matter. It concerns the people individually and collectively. It is national in its import. This leads me to conclude that the only way in which this problem can ultimately be met is by the inauguration of a compulsory national health insurance scheme which would provide no profit to any outside organization but which would be conducted by the government for the people and supported by the people.

This scheme would impose a compulsory tax on every employed wage earner in receipt of a salary or wage up to a specified amount. The plan should make it possible for a large portion of the population to pay in full whatever may be charged for needed medical service on terms which must be reasonable. It would relieve the strain on the ill, on the medical profession, and on the hospitals and would distribute costs in a manner that would be equitable and cause the least inconvenience to the largest number. The cost of medical care for those who cannot pay should be distributed according to ability to pay over the rest of the population of the community.

Help for the Middle Class Patient

I believe that, with some such plan in force, the adverse conditions under which the medical service and the people now suffer would be alleviated. The heavy drain on our institutions today results from the care of the indigent and of those who can pay only part of the cost of treatment. But with the easement of this financial burden, through health insurance for these groups, I believe our institutions would be in a position to afford the patient of moderate means medical care at far more reasonable rates than now obtain.

While I recognize the value of the voluntary health and hospital insurance plans which are spreading so rapidly under the names of "group

hospitalization" and "periodic payment plans," I feel that a compulsory health insurance plan is necessary for the following reasons:

1. Only under a compulsory plan will the benefits be extended to that group of the population which is most in need of them, namely, the less well paid workers and those working in small establishments.

2. A compulsory plan will doubtless be found to be simpler and more direct to administer and, therefore, more economical. There will be less tendency to create overlapping agencies.

3. Because it would apply to a large proportion of the people, a compulsory plan would have a more stable actuarial base.

4. Whether health insurance is voluntary or compulsory, some form of government regulation will doubtless be found essential to avoid abuses. Such regulation will be more effective if it can be started in the beginning.

Health Insurance vs. State Medicine

Compulsory health insurance is not state medicine. State medicine is the provision of medical service by the government. Compulsory health insurance is a plan by which medical service is provided by practitioners and institutions which do not surrender their nongovernmental character but payment is made from funds collected under governmental authority. State medicine is a plan for the taxpayers to pay the medical bills for themselves and everybody else; compulsory health insurance is a plan that enables and requires each family to pay its own medical bills. Compulsory health insurance, properly conceived, would not destroy the benefits that our hospitals have received from voluntary self-sacrifice and generous support by interested private citizens. If group hospitalization and similar plans are desirable, compulsory health insurance is a method for extending the benefits of these plans more nearly universally.

I am satisfied that in the large centers particularly our outdoor departments are today being exploited by those who are able to pay the hospital and the doctor, and it would therefore seem timely that our people should be asked to contribute through the medium of a relatively small levy toward the creation of an adequate and accessible public health service. In advancing this idea, however, we must be careful in the future to avoid criticism that has been leveled, and justly so, at the waste and planlessness of effort in affording medical care. The confidence and support of the public can be acquired only by cooperation between those who furnish services and those who pay if we are to obtain the benefits that are desired.

Social Service Under a County Medical Set-Up

By MARGUERITE L. SPIERS

Supervising Medical Social Worker, Alameda County Clinics, Oakland, Calif.

PRESENT trends in medical social work are closely related to current general developments in medical practice in the tax supported hospital, the private hospital and in the private office. These trends are also related to changes that have been occurring in the public administration of health work.

While the depression apparently has produced some of these developments, the entire fields of private medical practice and public administration of medical relief were in a potential stage of transition before the depression brought about certain crises which precipitated rather abrupt changes. These changes have had to do with the problem of the cost of medical care, trends toward public control of relief, the county as a unit in health administration and the old question of the medical social worker's function in the tax supported agency.

Keeping in mind the conditions and shifting emphases underlying community planning for medical care during recent years, let us turn to their manifestation in Alameda County, California, during the depression. Factors that have stimulated recent developments have been (1) increased intake of patients in public institutions and decreased budgets from tax sources, (2) a sincere desire on the part of organized medicine to lighten the burden of patients within the low income group and (3) the demand of the taxpayer for increased efficiency in the spending of his tax dollar.

Prior to August, 1932, Alameda County was operating four institutions for intramural care of the indigent sick and dependent poor. These were and are still supervised by an institutions

commission appointed by the county board of supervisors, with a full-time medical director responsible to the commission and to the supervisors. The supervisors also employed county physicians to care for indigent nonambulatory patients in their homes. These physicians were directly responsible to the supervisors.

The county institutions operated no clinics, and free and part-pay work was carried on by health centers which had grown up in each community, none of which was operated by the county. However, these health centers were subsidized by the county, and in return for the subsidy each center assumed responsibility for county out-patient work in its own community.

A social service department existed in the institutions, and in each of the larger health centers. These departments were officially not related to one another.

A physician appointed by the board of supervisors, as part-time health officer, served the unincorporated areas of the county.

Thus the official health work—for both treatment and prevention of disease—was broken up into a number of separate units which were unrelated and which were not under one administrative head.

For a number of years the county supervisors and various public and private health groups had looked toward centralization of health work. This idea had taken concrete form in various publications such as a study made by the institutions commission in 1927¹; a survey made in 1930 by Joseph W. Mountin, M.D.,² at the request of the county board of supervisors and the county

In Alameda County, California, the depression precipitated a long planned centralization of health activities under official control and presented an opportunity for organized medicine to conduct an experiment that will go far toward meeting the problem of the cost of medical care, at the same time keeping the practice of medicine in the hands of the private physician

tuberculosis and health association, and an article by Benjamin W. Black, M.D.,³ published in this magazine in 1931.

Late in August, 1932, the board of supervisors passed ordinances that brought all county physicians, clinics in health centers subsidized by county funds, and the county health department under the county institutions commission. This move placed responsibility for all county treatment and preventive services under the county medical director, and automatically centralized all medical social service.

Before the reorganization the institutions offered free medical treatment only to the indigent sick and dependent poor who were residents. The health centers cared for indigents and also for patients who were able to pay small fees. After the reorganization the county clinics of necessity limited their work to the same group served by the institutions. This limitation left no plan for patients who were able to pay a small amount but unable to pay the full doctor's fee.

At this point an arrangement for part-pay patients was initiated by the Alameda County Medical Association, and sponsored as a cooperative plan by the association and by the county institutions commission. Members of the medical association agreed to treat nonindigent patients privately for whatever fee they were able to pay, provided their ability to pay could be determined by the county medical social service, and provided any necessary social work could be rendered by the medical social workers of the clinics. Through this plan the work of the medical association and the institutions commission was linked by the joint use of the county medical social service.

Council Adopts Four Principles

In planning social work for the medical association the following principles were considered and adopted by the council of the association and by all concerned:

1. Because there is a social component in medicine, the services of the medical social worker are needed in the private practice of medicine as well as in the medical work of free clinics and hospitals.
2. The medical social worker may be expected to contribute the following types of service to the physician in private practice: (1) social study; (2) social case treatment, and (3) determination

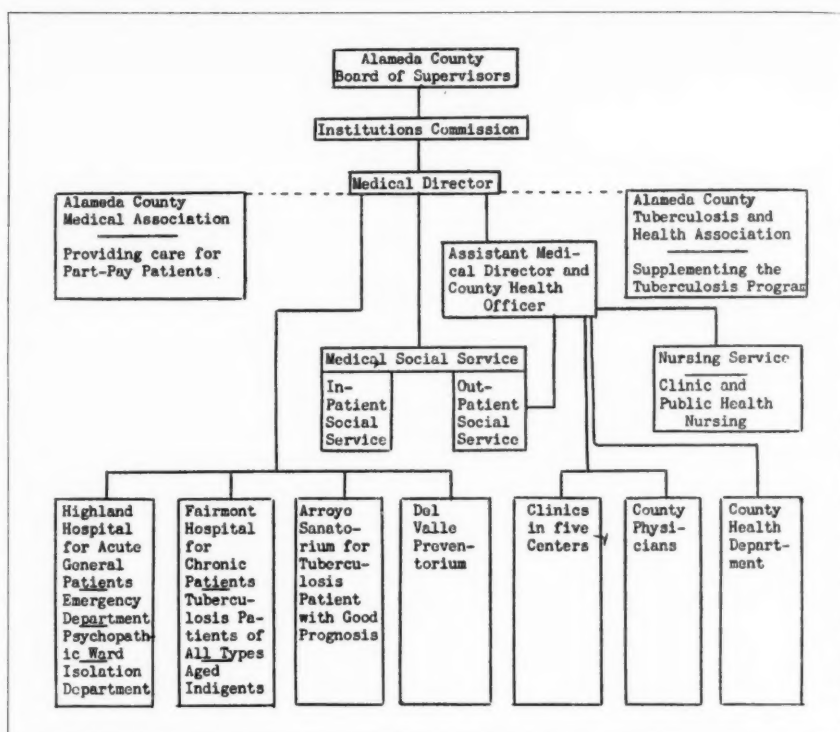
of patient's ability to pay for medical care by (a) securing accurate data regarding the financial status of patient and family; (b) evaluating these data in terms of the social and medical needs of the patient; (c) assisting patient and family to develop an attitude of willingness to pay for medical care, and aiding them to develop resources for payment within their own means; (d) securing relevant information from other agencies that have known the patient, and (e) as a by-product of the foregoing investigations, making recommendations as to fees patients are able to pay.

3. The type of financial investigation here discussed is not to be identified with nor does it take the place of the professional credit rating bureau.

4. The medical social worker does not presume to tell the physician what his private charges should be. Upon his request, his relationship becomes an advisory one.

The part-pay plan of the county medical association has been already described in detail by Black,⁴ Reinle⁵ and the California Medical Association.⁶ This cooperative plan with the official county medical organization makes possible adequate medical treatment for any person in Alameda County, at a fee commensurate with his ability to pay. During the first ten months that this plan has operated, 1,669 referrals of patients to private physicians were made.

Various community groups have turned their interest and support toward cooperative participation in the Alameda County plan. Notable among these groups is the Alameda County Tuberculosis



and Health Association, which is participating by (1) providing the salary of a trained medical social worker who, as a staff member of the clinic social service department, is responsible for medical social work with tuberculous patients in the county hospitals and clinics; (2) providing supplementary social work through the services of the association's executive secretary, and (3) providing part-time salaries for young physicians who wish experience in tuberculosis clinic work. These young physicians serve as members of the clinic staff.

Other community groups supplement county funds for glasses and orthopedic appliances when appropriations for such appliances run low. They also act in an advisory capacity to the county medical director regarding special health problems and needs in their own communities, thus continuing local community interest in a county-wide project.

The county medical social service—in-patient and out-patient—is an integral part of the county medical institutions. Its general set-up in relation to the entire organization is shown in the chart on the opposite page.

Five Social Service Functions

The functions of social service under the Alameda County plan are (1) to accept and review applications of all patients for free and part-pay medical care, and through a social study of each patient to determine his ability to pay, (2) to arrange a plan, within the means of each patient, for the medical care he requires, (3) to furnish a social study and conduct medical social case work for private patients referred by members of the county medical association, or for indigent patients re-

ferred by medical staff members and others in the county clinics or hospitals, (4) to mobilize community resources that will aid in dealing with patients' medical social problems and (5) to interpret the medical social work of the county to individuals and community groups.

Important effects of the depression in Alameda County have been (1) the precipitation of a long planned centralization of health activities under official control, and (2) presentation of an opportunity for organized medicine to conduct an experiment that will go far toward meeting the problem of the cost of medical care, and will at the same time keep the practice of medicine in the hands of the private physician.

New Demands Are Made

Both of these developments have brought renewed emphasis to certain established functions of medical social service, and have produced a demand for newer functions as yet not thoroughly tried out or generally analyzed. They have offered an opportunity for a demonstration never before possible in this locality, in the social aspects of admitting; the relationship of medical social service to private practice, and the functions of the medical social worker in tax supported agencies.*

*Read at the convention of the American Hospital Association, Milwaukee.

Bibliography

¹Spiers, Marguerite L., A Survey of Medical Social Service in Alameda County, Alameda County Institutions Commission, 1927.

²Mountin, Joseph W., Study of Health and Hospital Service, Alameda County, California, 1930.

³Black, Benjamin W., The Alameda County Plan—Twelve Years of Vital Progress, *THE MODERN HOSPITAL*, June, 1931.

⁴Black, Benjamin W., Private Hospitals Must Supply Care on Basis of Ability to Pay, *THE MODERN HOSPITAL*, Aug., 1933.

⁵Reinle, George W., Care of Indigents—Alameda County Plan, California and Western Medicine, July, 1933.

⁶California Medical Association, Committee on Public Relations, Bulletin, Feb., 1933.

Traveling Dietitian Serves Several Small Hospitals

Diets and food service in the very small hospital cannot be under the supervision of a trained dietitian, because the institution cannot afford to hire a specialist. Usually the superintendent herself must oversee the food service and oftentimes the cook who does the actual preparation of dishes is not highly experienced.

Soft diets, liquid diets and proper diets for cases of diabetes and nephritis need specialized knowledge on the part of supervisor and cook and thus present a complicated food problem for the small institution.

An experiment that worked out well in Canada was the employment of a traveling dietitian by the Saskatchewan department of health. The dietitian served all hospitals desiring her services in a certain area, her itinerary being arranged and transportation furnished by the provincial

department of health. The individual hospitals paid to the department her salary for two weeks, a month or two or three months as they could afford her services.

Even in hospitals where she stayed but two weeks, the dietitian was able to make a number of satisfactory adjustments in respect to diets and service. She was able to get the meals in better balance and of greater variety, and she could leave with those in charge of the kitchen a better idea of what makes up a soft diet or a liquid diet.

In small hospitals with training schools the dietitian was particularly valuable, as she gave regular lectures to the students and had both pupil and graduate nurses spend part of the time with her in the kitchen.

The depression made it no longer possible for a number of the hospitals to afford her services, so the project was reluctantly dropped.

Some of the hospitals have continued to hire dietitians for periods of two or three months on their own initiative, with worth while results.

Program of A. H. A. Convention

GENERAL BUSINESS SESSION

Monday afternoon, September 24

Chairman: Dr. Nathaniel W. Faxon, Strong Memorial Hospital, Rochester, N. Y., president.
Reports of committees.

PRESIDENT'S EVENING

Monday evening, September 24

Address: Dr. Nathaniel W. Faxon. Conferring of National Hospital Day Award by Veronica Miller, chairman, National Hospital Day Committee, Henrotin Hospital, Chicago.

ADMINISTRATION SECTION

Tuesday morning, September 25

Chairman: George D. Sheats, Baptist Memorial Hospital, Memphis, Tenn.; **Secretary:** A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul, Minn.

Report: Committee to Study Methods of Protecting Voluntary Hospitals From Unfair Competition, Dr. B. W. Black, chairman; presented by Dr. J. Rollin French, Golden State Hospital, Los Angeles.

Address: Group Hospitalization, C. Rufus Rorem, Julius Rosenwald Fund. **Discussion:** Frank Van Dyk, Hospital Council of Essex County, Newark, N. J.; Bryce L. Twitty, Baylor University Hospital, Dallas, Tex.

Address: The Need of a Psychiatric Ward in the General Hospital, Dr. Major H. Worthington, Research and Educational Hospital, Chicago.

Address: Clouds on the Hospital Horizon, Dr. Basil C. MacLean, Touro Infirmary, New Orleans.

Discussion: Dr. J. Rollin French.

Address: The Guest Suite, F. Stanley Howe, Orange Memorial Hospital, Orange, N. J.

Discussion: Rev. John G. Martin, Newark, N. J.

SMALL HOSPITAL SECTION

Tuesday morning, September 25

Chairman: Edna D. Price, R.N., Emerson Hospital, Concord, Mass; **Secretary:** James A. Hamilton, Mary Hitchcock Memorial Hospital, Hanover, N. H.

Report: Division on Accounting of the Council on Community Relations and Administrative Practice, Graham L. Davis, the Duke Endowment.

Address: What Are Small Hospitals Doing to Improve Their Community Relations? Dr. Channing Frothingham, Faulkner Hospital, Boston.

Discussion: Dr. Malcolm T. MacEachern, American College of Surgeons, Chicago; Matthew O. Foley, Hospital Management, Chicago; Esther Squire, R.N., Grinnell Community Hospital, Grinnell, Iowa.

Round Table: A. M. Calvin.

CONSTRUCTION SECTION

Tuesday afternoon, September 25

Chairman: Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y.; **Secretary:** H. Eldridge Hannaford, Samuel Hannaford & Sons, Architects, Cincinnati.

Address: Remodeling to Effect Economy in Power Plant, Charles F. Neergaard, Hospital Consultant, New York City.

Discussion: Sheldon L. Butler, Deputy Commissioner, Department of Hospitals, New York City.

Report: Committee on Hospital Planning and Equipment, Dr. B. W. Black, chairman; presented by Charles F. Neergaard.

Discussion: Robert E. Neff, University of Iowa Hospitals, Iowa City.

Report: Committee on Air Conditioning, Dr. C. W. Munger.

Address: What Shall Hospitals Do About the Weather? Prof. C. A. Mills, University of Cincinnati.

Discussion: James Govan, Architect, Toronto, Ont.

General business session.

ROUND TABLE

Tuesday afternoon, September 25

Leader: Dr. Warren L. Babcock, Grace Hospital, Detroit.

Topic: Broadening of Hospital Service to Physicians in the Community.

Topic: Health Programs for Nurses and Hospital Employees.

Topic: Hospital Perquisites of the Staff, Nurses, Employees, and Students, Dr. George O'Hanlon, Jersey City Medical Center, Jersey City, N. J.

Topic: Central Supply Service vs. Sectional Supply Service, Dr. Stewart Hamilton, Harper Hospital, Detroit.

Topic: Use of Trained Nurse Anesthetists in Hospitals, Florence M. Gipe, R. N., York Hospital, York, Pa.

Topic: Modernization of Hospital Plans and Partial Fireproofing.

HOSPITAL LIBRARIES

Tuesday afternoon, September 25

Leader: Robert E. Neff, University of Iowa Hospitals, Iowa City.

Report: Committee on Hospital Libraries, Perrie Jones, Department of Public Institutions, St. Paul, Minn.

Address: Brief Survey of Hospital Library Service in This Country and Abroad, Perrie Jones.

Address: Notes on the Reading of Mental Patients, Mary Morrissey, Sheppard and Enoch Pratt Hospital, Towson, Md.

Address: The Doctor and the Patient's Library, Dr. Gordon R. Kanuar, St. Paul, Minn.

TRUSTEES' SECTION

Tuesday evening, September 25

Chairman: Alba B. Johnson, presi-

dent, board of trustees, Jefferson Medical College Hospital, Philadelphia.

Address: Alba B. Johnson.

Address: How Should the Voluntary Hospitals Be Financed? Sherman C. Kingsley, Philadelphia.

Address: The Future of Hospital Finances, Thomas Gates, President, University of Pennsylvania, Philadelphia.

Address: Taxation and the Support of Hospitals, Franklin Spencer Edmonds, Philadelphia.

Address: Federal Relief and the Voluntary Hospital, Fred B. Whitney, president, board of trustees, Victory Memorial Hospital, Waukegan, Ill.

CHILDREN'S HOSPITAL SECTION

Wednesday morning, September 26

Chairman: Robert B. Witham, Children's Hospital, Denver; **Secretary:** Agnes O'Roke, Kosair Crippled Children Hospital, Louisville, Ky.

Address of Welcome: Dr. Nathaniel W. Faxon, president.

Address: The Shriners' Hospitals for Crippled Children, Hon. W. Freeland Kendrick, Shriners' Hospital for Crippled Children, Philadelphia.

Address: Poliomyelitis—Its History, the Prevention of Deformities, and the Protection of Muscles, Dr. John Ruhrah, Baltimore.

Address: Infectious and Contagious Diseases—Their Control in the Children's Hospital of Michigan, Margaret A. Rogers, Children's Hospital, Detroit.

ROUND TABLE ON RECORDS

Wednesday morning, September 26

Leader: Dr. A. C. Bachmeyer, Cincinnati General Hospital, Cincinnati.

Report: Committee on Clinical Records, Dr. Walter E. List, Jewish Hospital, Cincinnati, chairman.

Address: Medical Records as the Medical Statistician of an Insurance Company Sees Them, Dr. William Muhlberg, Medical Director, Union Central Life Insurance Company, Cincinnati.

Address: A Statistical Survey of the Methods of Cross Indexing and Filing Medical Records in Hospitals of 100 Beds or Larger, Dr. Halbert L. Dunn, University of Minnesota Hospital, Minneapolis.

Address: Medical Records as the Record Librarian Sees Them, Evelyn Vredenburg, Woman's Hospital, New York City.

Address: Medical Records as the Hospital Administrator Sees Them, Dr. Christopher G. Parnall, Rochester General Hospital, Rochester, N. Y.

Address: The New Standard Classified Nomenclature of Diseases, Dr. H. B. Logie, National Conference on Nomenclature of Diseases, New York.

COUNCIL ON COMMUNITY RELATIONS
AND ADMINISTRATIVE PRACTICE

Wednesday afternoon, September 26

Acting Chairman: Michael M. Davis, Julius Rosenwald Fund, Chicago.*Report:* Division on Medical Practice, Dr. R. C. Buerki, Wisconsin General Hospital, Madison.*Report:* Division on Nursing, Dr. C. W. Munger.*Report:* Division on Accounting, Dr. Basil C. MacLean.*Report:* Committee on Hospital Councils, Mrs. Mary Hicks Bachmeyer, Cincinnati.*Address:* The Work of the Advisory Board on Medical Specialties, Dr. J. S. Rodman, National Board of Medical Examiners, Philadelphia.

General business session.

Report: Nominating Committee, Dr. W. L. Babcock, Grace Hospital, Detroit, chairman.

NURSING SECTION

Wednesday afternoon, September 26

Chairman: Grace Phelps, Doernbecher Hospital for Children, Portland, Ore.; *Secretary:* Elizabeth F. Miller, State Board of Examiners for Registration of Nurses, Harrisburg, Pa.*Address:* The Eight-Hour Day as Regards the Hospital, the General Duty Nurse, and the Special Nurse, Susan Francis, R.N., Children's Hospital, Philadelphia, and president, American Nurses' Association.*Discussion:* Sister Helen Jarrell, R.N., St. Bernard's Hospital, Chicago.*Address:* Recent Trend in Nursing Education in Canada, Ethel Johns, *The Canadian Nurse*, Montreal, Que.*Address:* Recent Trend in Nursing Education in the United States, Sister Mary Therese, John B. Murphy Hospital, Chicago.*Discussion:* Claribel A. Wheeler, National League of Nursing Education, New York City.*Address:* The State's Responsibility to Nursing Education, James N. Rule, Superintendent of Public Instruction, Harrisburg, Pa.*Discussion:* Mary M. Roberts, *American Journal of Nursing*, New York City.SOCIAL SERVICE SECTION MEETING FOR
VOLUNTEERS

Wednesday afternoon, September 26

Chairman: Mrs. Ruth Boretti, Strong Memorial Hospital, Rochester, N. Y.; *Presiding:* Mrs. Katherine Van Slyck, Association of Junior Leagues of America, New York City.*Address:* What Volunteer Service Means to a Hospital Director.*Address:* Training Volunteers for Hospitals, Ruth Coon, Orange Memorial Hospital, Orange, N. J.*Address:* Organization of Volunteers in Hospitals, Elizabeth Lowry, Rochester General Hospital, Rochester, N. Y.*Address:* Satisfactions and Dissatisfactions of Volunteer Service, Mrs. William Gunn, Cleveland.GENERAL SESSION ON HOSPITAL
INSURANCE

Thursday morning, September 27

Presiding: Dr. Nathaniel W. Faxon. *Address:* What England Has Done, Sidney Lamb, Merseyside Hospitals Council, Inc., Liverpool, England.*Address:* How the American College of Surgeons Wants It Done, Dr. Malcolm T. MacEachern.*Address:* What the United States Wants to Do, Michael M. Davis.*Report:* Resolutions Committee, John R. Mannix, University Hospitals, Cleveland, chairman.

SOCIAL SERVICE SECTION

Thursday morning, September 27

Chairman: Mrs. Ruth Boretti; *Secretary:* Margaret Bradley, New Haven Hospital, New Haven, Conn.; *Presiding:* Dr. Earl Bond, University of Pennsylvania, Philadelphia.*Address:* The Responsibility of the State and Federal Governments for Care of the Indigent Sick in Hospitals (speaker from the FERA).*Address:* The Place of the Medical Social Worker in the Federal Relief Program, Lena R. Waters, Hospital of the University of Pennsylvania, Philadelphia.*Discussion:* Edith M. Baker, Washington University Clinics, St. Louis.

TUBERCULOSIS SECTION

Thursday morning, September 27

Chairman: Dr. C. H. Sprague, Broadlawns-Polk County Public Hospital, Des Moines, Iowa; *Secretary:* W. C. Reineking.*Address:* Medical Administration—Individual or Mass Treatment? Dr. W. C. Reineking, Lake View Sanatorium, Madison, Wis.*Discussion:* Dr. Charles Hatfield, Philadelphia.*Address:* Management of Pneumothorax and Its Complications, Dr. Martin H. Collier, Grenloch, N. J.*Discussion:* Dr. J. W. Culler, Philadelphia.*Address:* The X-Ray in the Sanatorium: Its Maximum Use and Benefit, Dr. Ezra Bridge, Rochester, N. Y.*Discussion:* Dr. V. F. Cullen, State Sanatorium, Md.*Address:* Pleurisy With Effusion in Tuberculosis, Dr. F. M. McPhedran, Philadelphia.*Discussion:* Dr. R. T. Ellison, Philadelphia.*Address:* The Problem of Diet in a Tuberculosis Sanatorium, Dr. R. S. McCutcheon, Mont Alto, Pa.*Discussion:* Dr. M. W. Newcomb, Brown's Mills, N. J.ROUND TABLE ON PRACTICAL SANA-
TORIUM SUBJECTS

Thursday afternoon, September 27

Chairman: Dr. C. H. Sprague, Broadlawns-Polk County Public Hospital, Des Moines, Iowa; *Secretary:* Dr. W. C. Reineking.*Symposium:* The Present Aspects of the Etiology of Tuberculosis—Do We Need to Change Some of Our

Ideas? Dr. C. H. Sprague, section leader.

Symposium: What Can the Superintendent of a Sanatorium Do to Enhance the Recovery of His Patients? David R. Lyman, section leader.*Symposium:* After-Care, Dr. H. A. Pattison, section leader.

DIETETIC SECTION

Thursday afternoon, September 27

Chairman: Lenna F. Cooper, Montefiore Hospital, New York City; *Secretary:* Mable MacLachlan, University Hospital, Ann Arbor, Mich.*Address:* The Trend Toward Consumer Standards and Their Value to the Institutional Buyer, Paul M. Williams, U. S. Department of Agriculture, Washington, D. C.*Address:* Food Purchasing for the Hospital, Adeline Wood, Mount Sinai Hospital, New York City.*Symposium:* The Food Clinic—A Necessary Coordinating Hospital Service Unit, John N. Hatfield and Martha A. Alderman, Pennsylvania Hospital, Philadelphia.*Address:* The Dietary Department From the Viewpoint of the Hospital Administrator, Dr. Paul Keller, Newark Beth Israel Hospital, Newark.*Address:* Selecting Your Dietitian, Mrs. Quindara Oliver Dodge, Simmons College, Boston.ROUND TABLES ON SOCIAL SERVICE
AMERICAN ASSOCIATION OF MEDICAL
SOCIAL WORKERS

Thursday afternoon, September 27

Leader: Elizabeth McConnell.*Topic:* Social Recording on Medical Records, Elizabeth McConnell, Mandel Clinic, Michael Reese Hospital, Chicago; Beatrice Hall, Neurological Institute, New York City; Agnes Schroeder, Western Reserve University, Cleveland.*Leader:* Henri-Ette Kirch, Graduate Hospital of the University of Pennsylvania, Philadelphia.*Topic:* Professional Relationships, Elizabeth Rice, New Haven Hospital, New Haven, Conn.*Leader:* Ida M. Cannon, Massachusetts General Hospital, Boston.*Topic:* Social Teaching of Medical Students.

PUBLIC HOSPITAL SECTION

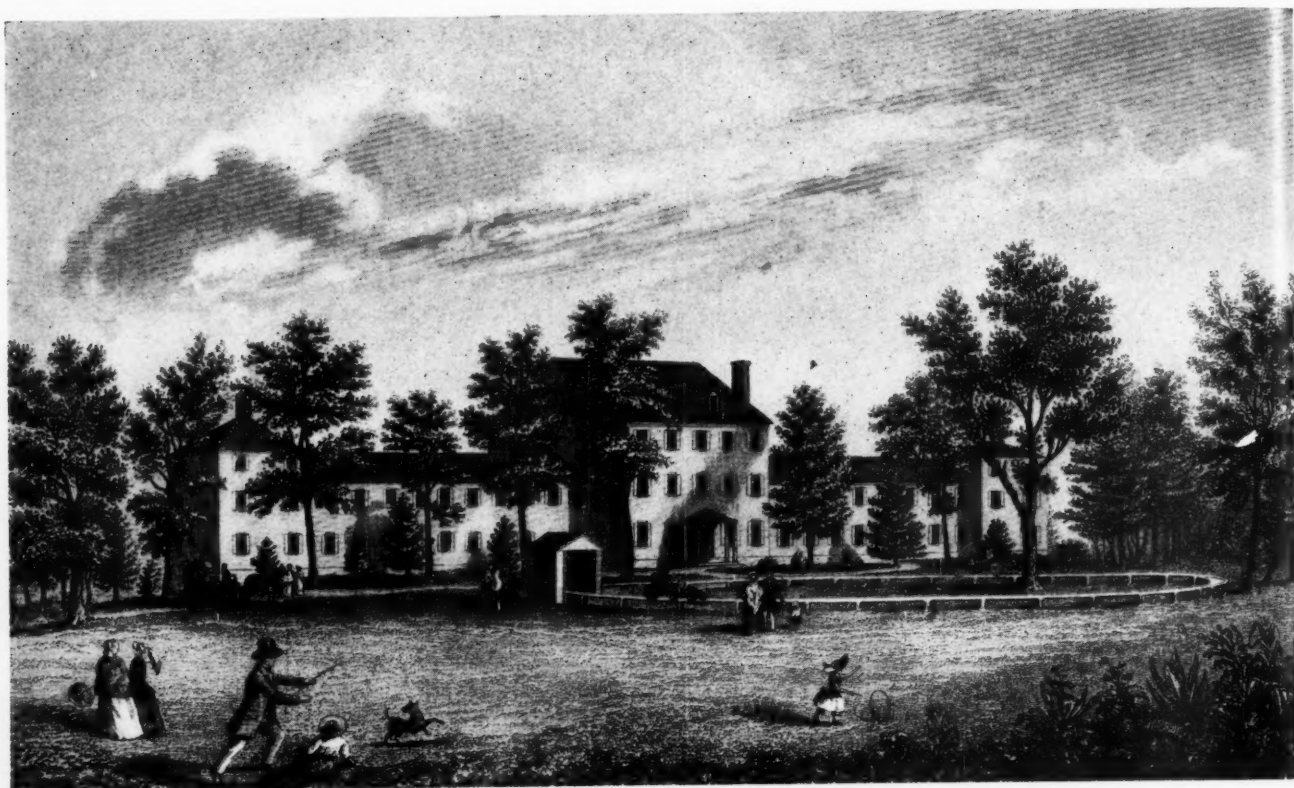
Thursday evening, September 27

Chairman: Dr. John D. McLean, Rush Hospital for Consumptives and Allied Diseases, Philadelphia.*Address:* The Type of Patient Who Should Be Cared for in a Public Hospital, Dr. Walter S. Goodale, Buffalo City Hospital, Buffalo, N. Y.*Address:* How a Public Hospital Could or Should Be Formed, Hon. Edwin R. Cox, Philadelphia.*Address:* Supervision of Finances and Service in Public Hospitals.

CLOSING SESSION

Friday morning, September 28

Chairman: Dr. Nathaniel W. Faxon. Induction of new officers. Unfinished business. New business.



Two early Philadelphia institutions—Friends Hospital, as it looked in 1813, and Pennsylvania Hospital, chartered 1751.



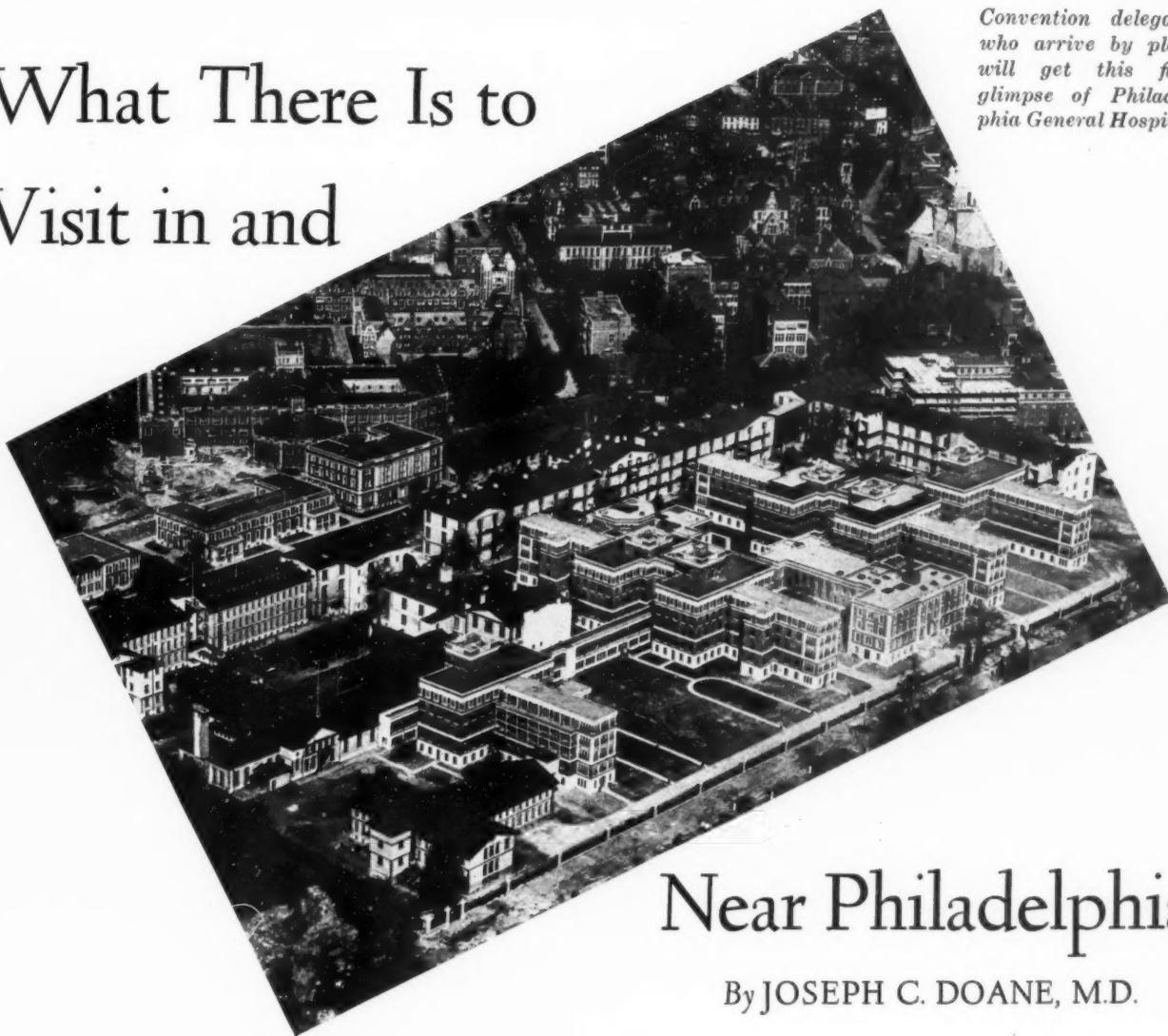
SOUTH EAST VIEW OF THE



PENNSYLVANIA HOSPITAL

What There Is to Visit in and

Convention delegates who arrive by plane will get this first glimpse of Philadelphia General Hospital.



Near Philadelphia

By JOSEPH C. DOANE, M.D.

MANY points of historic as well as hospital interest will engage the attention of visiting hospital executives and their friends who are in Philadelphia for the American Hospital Association convention the week of September 24.

Philadelphia has long been pardonably proud of the splendid traditions of its institutions of medical learning and of the fact that the first practical exemplification of the advantage of institutional treatment of the sick took place there. For 125 years following the discovery by Hendrik Hudson of the Delaware bay and river, the latter then known as the South River, the practice of medicine seemed not to require the assistance of an institution for the collective treatment of the sick. Then the residents of the town of Philadelphia were apparently economically comfortable and the sick were cared for in their homes.

But during the latter part of the seventeenth and the early part of the eighteenth century, a roving,

improvident, seafaring class of persons began to follow the lanes of commerce and to settle in Philadelphia. There arose then, for the first time, the need for the establishment of an institution for the housing of the indigent and for their treatment when they became ill. The Quakers, taking the initiative in meeting this need, founded the first almshouse in Philadelphia, intended solely for treatment of the poor of their own denomination.

As early as 1712, the city council of Philadelphia passed a minute, recognizing the fact that since the poor of the community were daily increasing, some haven of refuge should be provided for them at the public expense. It was not, however, until 1732 that the first public workhouse was constructed. This particular event is of interest to all who are concerned with the institutional care of the sick because from this small almshouse has grown a great city hospital housing today more than two thousand patients — the Philadelphia General.

In 1751 a charter was issued to Pennsylvania

Hospital, now located at Eighth and Spruce Streets. Benjamin Franklin in his "Brief Account of the Pennsylvania Hospital," published in 1754, makes the following remarks:

"Late in the year 1750, some persons who had frequent opportunities to do so observed the distress of such distempered poor as from time to time came to Philadelphia for the advice and assistance of the physicians and surgeons of that city, how difficult it was for them to secure suitable lodgings and other conveniences proper for their respective cases and how expensive the providing of good careful nursing and other attendance, for want thereof, many must suffer greatly, and some probably perish . . ."

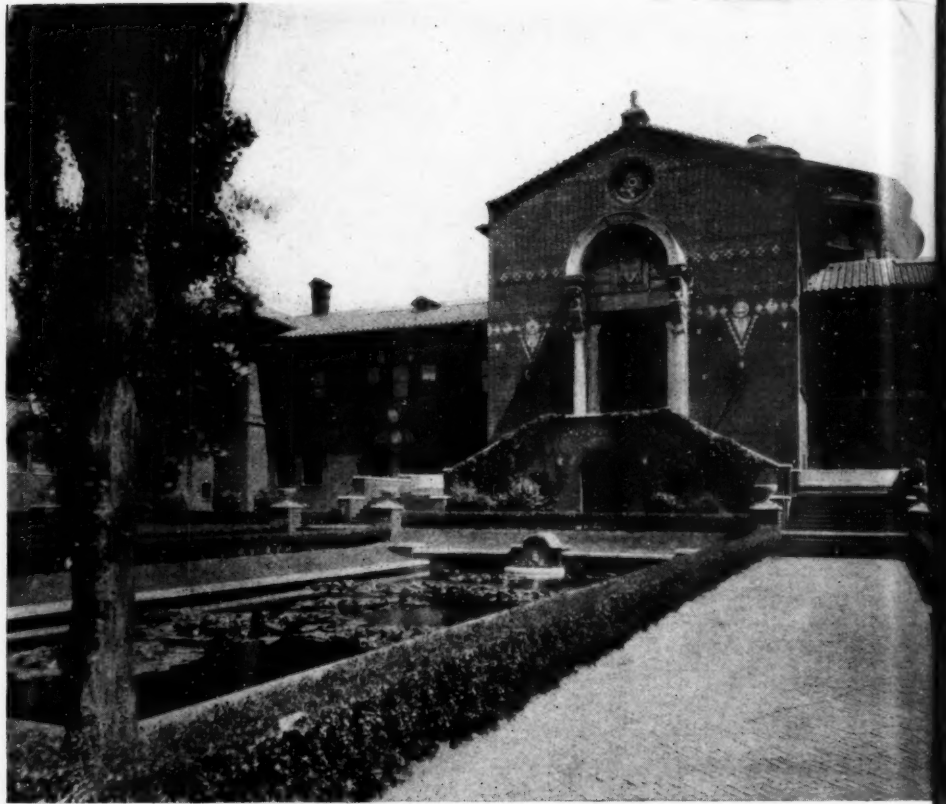
Franklin continues by describing the advantage of collecting the sick so that they might be under the care of the skillful practitioners of the day, and concludes by stating the need for the organization of such an institution. And so there came into existence Pennsylvania Hospital which for 183

years has so splendidly ministered to the sick of all creeds and colors and maintained so finely the high traditions set for it by its founders.

It is of interest to the hospital historian to read of the friendly controversy that has existed for many years as to whether Philadelphia General or

Pennsylvania Hospital is the first hospital in the United States. There can be but little doubt that the first almshouse infirmary was in existence almost two decades prior to the construction of Pennsylvania Hospital. There can be likewise no doubt of the fact that the first incorporated hospital in the United States is the Pennsylvania Hospital.

The history of medicine and of hospitalization in Philadelphia is closely intermingled with the history of the turbu-



September, 1934

A Philadelphia parkway with fountain and the University of Pennsylvania Museum (opposite page); below, the Art Museum; at the right, a view at Valley Forge near by.

lent days of the Revolutionary War, the War of 1812 and the Civil War. It is a tragic tale that the historian narrates concerning the evacuation of the Philadelphia Almshouse by the British General Howe during his occupancy of Philadelphia in 1776. It was then that the army of the King took military possession of the Philadelphia Almshouse, transferring in the dead of winter about two hundred miserable, decrepit, half starved creatures, some to private dwellings, some to the Free Masons' Lodge and some to Carpenter's Hall. When the invaders left the city in June, 1778, only eighty-two of the original two hundred patients were still alive to be retransferred to their former quarters. Still further did Pennsylvania Hospital and the Philadelphia Almshouse contribute to the care of the ailing Revolutionary soldiers when those suffering with contagious diseases, such as putrid sore throat and smallpox, were housed in these hospitals, much to the detriment of the patients already there.

Longfellow told a pretty tale of the reunion of Evangeline and Gabriel in a Philadelphia alms-



house. This story has much to intrigue the imagination, and hardly a year passes but that some writer in the lay press does not endeavor to locate the graves of these fictitious characters.

The roster of physicians attached to these two institutions during revolutionary days represents an enumeration of the illustrious in the medical circles of the time.

There were Benjamin Rush, called the American Hippocrates; Thomas Bond, who delivered the first clinical lecture in the United States and has been called therefore the father of clinical medicine; Cadwallader Evans, a pupil of Doctor Bond; Caspar Wister; Samuel Duffield and many others occupied the foremost ranks in the respect of their fellow citizens and in their medical accomplishments of the day.

No sojourn in Philadelphia should be complete for hospital workers without visits to



Philadelphia General Hospital with its more than two thousand beds and its seven million dollars' worth of buildings constructed in the past decade, or to Pennsylvania Hospital, where may be seen the famous picture, "Christ Healing the Sick," and the historical documents in the library of that institution. The main building of Pennsylvania Hospital is the oldest building in the United States continuously employed for the care of the sick. A statue of William Penn on the lawn in front of this building is reminiscently suggestive of the change that has taken place in the lives of the citizens of Philadelphia since the building was constructed. One may imagine the thoughts of William Penn could he but look out upon the teeming multitudes that flow back and forth on Pine Street which was a dusty farm road when Pennsylvania Hospital was constructed.

The story of the development in the practices and procedures of these two institutions is of much interest. At Pennsylvania Hospital may be seen the first clinical amphitheater in America and early implements used in the incarceration of the mentally ill. Doctor Rush's "tranquilizing" chair, a hideous invention for the quieting of mentally deranged persons, is a relic of by-gone days.

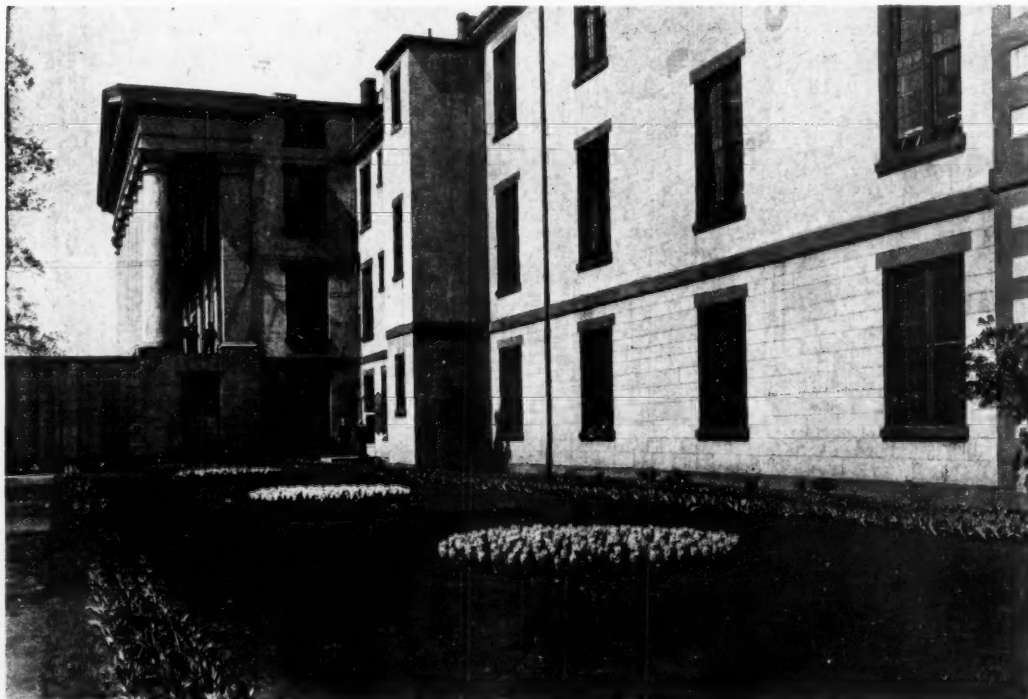
Early Board Members Fined for Being Tardy

In the minutes of the early governors of both of these institutions one observes specific comments and penalties for members of hospital boards who failed in punctuality or attendance. For example, among other rules drawn up by the managers for the conduct of Pennsylvania Hospital was one pro-



The smart new building occupied by Wills Hospital.

viding for a fine to be levied upon any manager who failed to attend the meetings of the board, or who was unpunctual in attendance, "the town clock or when that did not strike, the watch of the oldest person present to be the standard to determine the time." The difficulties encountered in securing prompt attendance of members of the visiting staff, the insistence that all ward patients should be treated free and the question as to whether those suffering with venereal disease should be excluded were questions debated in these meetings.



Administration building and court at Philadelphia General Hospital; the structure was erected in 1832.

The medical department of the University of Pennsylvania, through devious yet always progressive stages, emerged from being a department of the College of Philadelphia, to the medical department of the College of the State of Pennsylvania, to the medical department of the University of Pennsylvania.

Morgan and Shippen First Professors of Medicine

In 1765, John Morgan was elected by the directors of the early institution to the first professorship in medicine in America, and four months later, Shippen was made professor of anatomy and surgery. These two young men, 169 years ago, inaugurated the first course in medicine in this country. The bedside teaching performed by the professors of this school has largely affected the hospital practices and population of Pennsylvania Hospital, Philadelphia General Hospital and the University and Graduate Hospitals of Philadelphia for many years.

The University of Pennsylvania medical department is not the only medical school in Philadelphia which has exerted a beneficial influence on hospitals and patients. The Jefferson Medical College founded in 1825, the Hahnemann Medical College in 1848, the Woman's Medical College in 1860, the Medico Chirurgical College in 1881, the Philadelphia Polyclinic and College for Graduates in Medicine in 1883, and the Temple University Medical Department in 1901, all have had associated with them large hospitals which they have employed for the practical instruction of their students in medicine and surgery.

It can be said, therefore, that the majority of

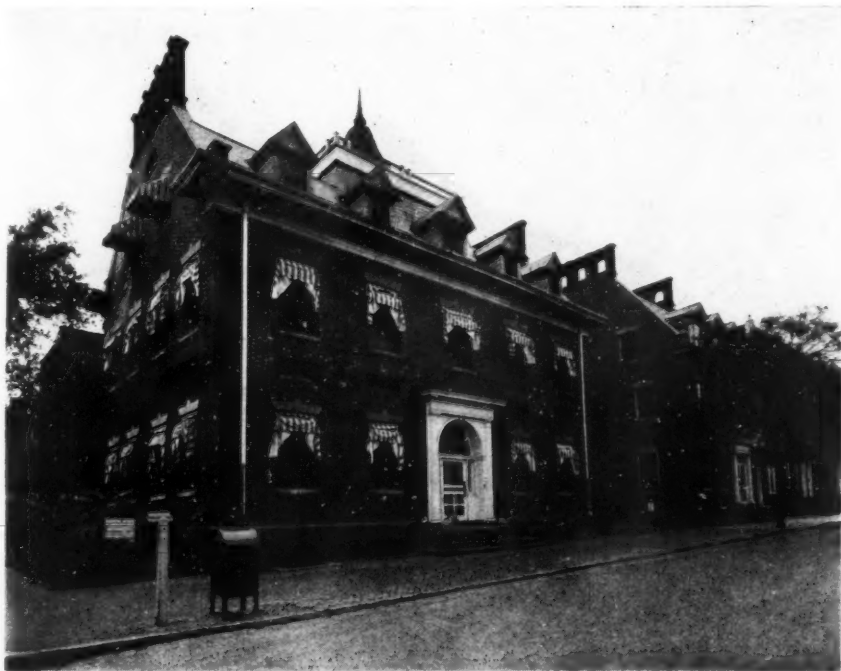


The maternity building of Pennsylvania Hospital, one of the newer structures in this great group.

hospitals in Philadelphia today have received through past generations the scientific stimulus which comes only from medical teaching and there are few institutions in which the professors of these medical schools have not been at some time engaged either in the scientific pursuit of their own profession or in the actual instruction of medical students.

Philadelphia, in common with other large cities, has been afflicted in the past with many devastating disease epidemics. From these have emerged hospital heroes and heroines as well as new institutions which were thus found necessary for the care of the peculiar types of disease occurring in a large number of cases.

The yellow fever epidemic of 1793, in which more than 25 per cent of the population of the city succumbed, displayed the



St. Christopher's Hospital for Children is at Lawrence and Huntingdon streets.



heroism of two laymen, Stephen Girard and Peter Helm, and two physicians, Jean Devezze and Benjamin Duffield. From this epidemic developed the splendid Philadelphia Hospital for Contagious Diseases with its present capacity of one thousand patients.

So much for medical historical Philadelphia. Other points of interest are sure to attract visiting hospital executives and their friends. For instance, no historic pilgrimage is complete without a visit to the house where Betsy Ross is said to have sewed the stars on the first American flag. Then there is the cemetery where repose the remains of that printer, philosopher and flier of the kite that first brought down sparks of electricity from the clouds — Benjamin Franklin. The home of Liberty Bell, Independence Hall at Sixth and Chestnut Streets; Carpenter's Hall, already mentioned; Christ Church, and Old Swedes' Church are but a few of the historical reminders of other times. The visitor to Philadelphia's splendid new Convention Hall, Franklin Institute with its planetarium, the busy department stores, publishing houses, schools and churches, should also make a pilgrimage to Valley Forge and visualize again the ravages of the winter endured there by our heroic ancestors. Let him not forget as he journeys along Germantown Avenue that here was fought a decisive battle and that even now the eyes of an observer can detect the scars made by the lead of British and Continental guns.

Cooper Hospital, Camden, N. J., is just across the river from Philadelphia. The four-gram radium bomb at the American Oncologic Hospital is shown below.



Hospital Development and Support— A Public Relations Problem

By PERRY ADDLEMAN

Chicago

Part II

LAST month's article dealt with methods by which social institutions in America sought and obtained interest and support for their innumerable development projects during the fifteen years from 1919 to 1934—particularly during the velvet decade between 1919 and 1929.

During that period the spasmodic, highly intensive and rigidly organized fund-raising campaign was successful in securing hundreds of millions of dollars for hospitals, colleges, universities and similar institutions. In the main the campaigns employed an emotional and irrational appeal but they were so high pressure that they got results—and money—for a while.

Their aftermath has been such, I believe, that the short-time, high pressure fund-raising campaign can no longer be recommended as an effective means whereby even immediate results and objectives may be obtained. It has accomplished its own elimination as a recommendable procedure except within narrow and well defined limitations.

Why the High Pressure Campaign Fails

It is failing for a number of reasons. The first and most obvious is that Americans have not and, probably for quite a while, will not have heaped up millions to toss into any project at a mere signal from the tom-tom beaters. Americans have enough money to support any sound development in their social institutions but social institutions are going to earn it a different way than they have in the past if they are to get much of it. Unless, of course, it may be said that the public never learns a lesson. But the high pressure campaign is incorrect in most instances and fails today for other reasons also, the surest of which is that it militates against an orderly, rational development of an institution's capacity to serve a community and fulfill the community's real needs. •

Nevertheless, American social institutions, hos-

Volumes, good and not good, have been written about what to do and what not to do in publicity. Most of them may have done more harm than good because even the few which are competently written obscure the basic essentials of correct promotion by stressing the technical procedure

pitals included, are going to require many millions more to carry on other developments more greatly needed now than previous developments were when they were undertaken. Where is this money coming from and how will it be obtained? This and a subsequent article will attempt to deal with these questions and with demonstrably sound promotional and development methods—methods which it seems must be employed if results are to be attained in the future.

Can we, however, look at fifteen years of fund-raising campaigns and content ourselves with the statement that the *means* of obtaining interest and support for social institutions was perhaps incorrect and is failing? I think not. Because, in reality, the character of the means used to obtain support and funds was, in many instances, no more or less than a reflection of the character of development going on within the institutions themselves.

Let us go back to the first article and tie up several separated and incidental statements made in it. Perhaps, behind them, another pattern of thought and action more fundamental than a discussion of mere means is to be found—thought and action which, in fact, predetermined the exterior means and methods of promotion used in the past.

Near the beginning of the first article it was said that the history of the internal development of social institutions in America between 1919 and

1934 was to be found in a close and critical study of fund-raising methods which had been more or less successfully employed.

Later it was stated that the promotional methods used for an institution reflect the soundness of its internal development plans. This might be changed to read that promotional methods, where incorrect, were no more incorrect than the internal development in behalf of which they were employed.

Again, it was stated that the hysteria and rote of the emotional appeal was an offense against all that is scientific and rational, the very embodiment of which was presumed to exist in the institutions for which such appeals were being made.

Objection was also made that what improvements had taken place in promotional methods, marked though they were, were improvements in superficial functional methods of procedure rather than essential changes in concept. Finally, it was suggested that sound procedure would follow when it was realized that promotional methods must be organic with renewed usefulness.

The implications and inferences of all these statements are similar and direct, namely, that public relations and promotional methods *are* organic with internal development. And that correct methods of obtaining public interest, support and funds can only result from, and are one with, scientific and rationally planned development.

But, it will be argued, such a theory, if carried to its logical conclusion, implies that the value of a product may actually be affected by the sales methods used to merchandise it. Surely the quality of a product cannot determine, or be changed by, the sales methods used to get acceptance of it. Surely there is no necessary connection between quality of product and methods used to sell it.

The theory does imply just that. It might be factually demonstrated, I think, that the value of even a material product is ultimately affected by the sales methods used for it and that ultimately there is complete connection between quality of product and sales methods necessary to get acceptance for it.

It is a practical fact that a high quality product properly priced will not need high pressure sales methods to gain wide acceptance, and conversely it may be true that its price-quality cannot be suc-

cessfully upheld against assaults made on it by high pressure, tricky or coercive sales methods used to sell it.

In social institutions the connections between product and promotional methods used for it are infinitely stronger, more direct and more positive. The material product of industry can be measured by objective test mechanisms. Once turned out, its quality does not depend upon what someone thinks of it nor does it change. Only the quality of successive units changes as conditions may be altered. But the product of a social institution is peculiar in that it is always a ministration to the body or mind of an individual, and at least half of its value is in the mind of the individual who receives the ministration. The quality of that half changes from time to time and all the time as the relations of the individual to the institution change.

No one will doubt that hospital service or an education may be good or bad, sound or unsound, depending upon what the recipient thinks of them. How much more certain is it then that there is a direct and necessary connection between the product of the institution (the institution's work and development) and the public relations and promotional methods used for the institution.

The uniformity and regularity of this connection between internal development on the one hand and promotional methods on the other, and the effect of each upon the other, has not been recognized and discussed widely, and naturally it has not been accepted as fact by any group of social institutions. But then, neither have social institutions ever thought it necessary to delve into the essentials and fundamentals of public relations and promotional work. Up until four years ago social institutions were too busy growing to think very rigorously about sound and rational objectives, social utility or planned development and promotion. And the American public was too busy making money to ask questions.

Even now, acceptance of the idea would be disquieting in some quarters. The rather general thought has been that if promotional efforts were sufficiently organized, anything wanted might be obtained. To think that no such thing is true; that the beginning of useful and successful development is to be found in really wanting the right things; that the correct technique of promotion is a consequence of wanting the right things—such thoughts may even yet be somewhat shocking to some individuals and groups.

In any open discussion of public relations, the important thing is to isolate fundamental generalities of promotional procedure. Once they are well defined and faithfully held in view, one may rest assured that correct practical application can be

Up until four years ago social institutions were too busy growing to think rigorously about rational objectives, social utility or planned development

made when occasion indicates the need. And at reaching conclusions with regard to fundamental generalities it might be well to assume the attitude of the noted man dealing in the pure science of chemistry who, after enunciating a newly discovered law of chemical action, was asked by one of his students if the law had any practical application to commercial chemistry. He answered that he was not the least bit interested in whether or not his idea had any practical application or commercial value; that he was interested only in the scientific fact; but he ventured that others would, no doubt, find ways to make money out of the idea.

For certain purposes these articles might be concluded right here but, having the interests of one engaged in practice, I cannot resist the temptation to write about the practical application of such ideas as may approach the status of fundamentals. In the light of what has been discussed here, can we outline a practical procedure for development and promotion that might have wide application to the hospital field? Let us see.

If we are to make application of fundamental ideas of method we must have a hospital, so we shall select a so-called average hospital in a middle-sized city and go to work. Our hospital is the material embodiment of the noblest science of civilization, so development and promotional work must be in character—rigorously scientific. And it is the most humane science, so our work must be humane and equitable in its human relations.

A start will be made by studying the health and public health problems of our city and all vitally related problems. The first problem is to find out what the needs of the city are in these fields. We shall need some help. The real needs of the city cannot be determined unless we have the help of every truly public spirited citizen with whom it is possible to come in contact. We can, of course, speculate about the needs of the city in terms of hospital service, and we should do that. And we have well routinized, orthodox ideas about what good hospital service is. But we are scientists now, not politicians, or hobbyists. And we must remind ourselves that we are not endeavoring to prove orthodoxies or what we have thought to be true.

The scientist is not interested in proving ideas. He only tests ideas. If he is a good scientist he is only vaguely interested in proving the value of even his own ideas (shades of a departing vanity!); he doesn't have to be. Because he has a method which is more invincible than the content of any idea, even his own. He speculates, to be sure, but only for the purpose of providing more material to be tested. That a few ideas are proved true are but highly valuable incidents in practice of the scientific method.

We must do nothing arbitrary to restrain free expression of even bad ideas. Unbiased exploitation of unsound and impractical ideas will wear them thin and dispose of them

Naturally, we begin by asking questions of all the responsible persons of sound mind we meet. We want to know what they think is needed. We shall be very candid about this whole procedure, too. We will tell anyone who asks about it or who seems perturbed by our questions that he has always been in the business of paying for sickness and health, his own and the city's, despite the fact that this may be the first time we have really gone to work for the fellow who pays the bills. We must be sure to tell him also that he is, in lieu of some of the cash expense, helping us find out what the city needs in the way of hospital and health service while, at the same time, he himself is learning—probably for the first time in his life.

Right here a great deal of caution must be exercised. We have the purely technical ability of hospital management. He has not. We will wear out our welcome in a hurry if we let our questions veer from *what* the community may need to *how* to get what it needs. We overtax his patience if we ask him to do things he thinks he has hired us to do. He is not interested in the technical details of management. And, besides, how to get what we all need is not an appropriate question yet.

By now we are in the most fascinating game on earth. Everyone who plays it is bound to like it. No idea, sensibly stated, is rejected. The mathematical laws of probabilities are beginning to work for us. We begin to remember that many scientific ideas of almost revolutionary value frequently appeared to be accidents but were in reality but the product of a sound mind working in an unimpeded and detached environment. No idea is absurd. So we take any idea stated in understandable English and some that are not, and begin, let us say, to *process* them.

All sorts of simple things are done with these ideas of what the city needs. We will classify them and throw them into categories. Check out duplications. We will recast suggestions in terms of fundamental ideas. Presume them to be sound and build corollaries around them just to see the patterns they form. We reverse conclusions and premises. Turn ideas upside down. And inside out. And if they are still holding together after that, we will throw them back, individually and in mass,

at the men and groups who gave them to us. And advise that they tear them to pieces if they can.

Meanwhile, other work is cut out for us. It is our job as suggestions are being received and processed, to shape up the basic data related to these ideas and suggestions. All such basic data must be coordinated and arranged to show and interpret the significance and broad effects of the various ideas that are withstanding the grind, so that when they are *processed* and reformed and taken back to their sponsors, a sponsor may pass more intelligent judgment upon his own idea than he could at the time he suggested it.

We are having all sorts of trouble in our own minds, too. Our training and experience almost doom us because we want to jump at conclusions about some of these ideas. We want to say that some of them are good. And that some of them are unsound and impractical. Here is a real test of our fidelity to a scientific method of promotion. We will have to do the very best we can to avoid temptation and if we ever put faith in scientific methods we must do it now. Anyway we had better reserve our opinion; it may be sought later.

Patience will come with remembrance that the surest test of an idea is to be found in throwing it back and forth enough—freely enough. We must do nothing arbitrary to restrain free expression of even bad ideas. Unbiased exploitation of unsound and impractical ideas will wear them thin. And completely dispose of them. Agitation will only polish an idea if it is made of the right metal. Ideas, scientifically handled, have a way of taking care of themselves.

Creating Genuine News Values

In this connection, the assistance of newspapers should not be overlooked. They will help right from the start. When they begin to see that behind our backs we have no axes to grind, preconceived and pet ideas to prove, or moss covered dogmas to propagate, they will work as closely with us as any other agency in town. They will help us *process* ideas. That is their business. We may have slow going with them at first, if, perhaps, in the past we have lived with them in a kind of mutual distrust and truce of abuse. But they understand the cost of health and sickness, and they will almost have to gamble that we are on the right track until we may prove that we are not. Certainly, they will let us prove the candor and sincerity of our methods as we go along.

Of course, they may be unfair about it. But if they are we need not be alarmed. They are the ones who will suffer. If we are preparing scientifically to uncover and meet needs demonstrated by objective study and tests to exist in our city, our work

is useful. We are creating genuine values. Our studies alone are a public service. Publicity in both technique and content is completely interwoven with the creation of such values. These do not make news and create interest; they are news and awaken interest. Newspapers merchandise reader interest and news values. And if we have those products to give them they will be coming to us after a while.

Most all other means of publicity may be used equally well and will lend themselves in their right places to exploitation of the work we are doing. Exposition in every dignified form will assist us in our studies by getting us cooperation in them. It will prepare the way for us as we go, and educate the city to what we are doing. Moreover, throughout all our work we will see more clearly every day that the thing which is most interesting to the public, most productive of active cooperation, the best promotional and most educational thing we do, is to make real contacts with responsible men; ask them real questions and really listen to the answers they give us. We begin to get our first slant on practical application of the thought that promotional methods are organic with our internal development and the work we have to do.

Finding What the City Needs

Finally, by process of elimination and logical selection, we get clear-cut, well knit and well defined ideas of what the city needs in the way of hospital service and kindred services. What is more important, responsible citizens get a clear idea of what the city needs—at least what they think it needs. And it might be added that no one has ever yet offered a better way of finding out what the needs of a city are than that of articulating the considered requests of its responsible citizens who have been well educated to the problems and questions involved.

Honest research methods have proved quite simple. Scientific methods are simple—childishly simple. That is probably the reason they are so difficult for complexly organized adults to employ. We have had to fight all the way against what we were perfectly certain was needed before we started to investigate. We have found out that the city needs some hospital services we had not thought were needed. Likely as not we find that we have been trying to sell some services no one wants to buy. And it is important, I think, that we have also demonstrated by objective judgment that most of all we do is needed and quite right.

We have been surprised, too. Such procedure never fails to turn up some complete surprises. Some perfectly good and fresh ideas about hospitalization have come from men who never were in

the field and never will be. We probably would not have had such ideas from them had they been hospital men.

Now the first and most important part of development and promotional work is done. Our problems are organized and laid out. We know what they really are and that is the biggest half of solving them. Researches into the needs of our service area will continue, of course—they should never end—but planning to meet the needs already well outlined by work done thus far is the second step which we must now undertake. And we had better do equally good work here. We had better succeed in our planning because in the process of scientifically isolating and defining the needs of the city we have made our responsible citizen keenly conscious of what he needs and wants and thinks he ought to have, and if we cannot find a way to give it to him at a fair price he will also discover that he does not need us any longer.

But if we fall back on a scientific method of planning, he will help us again. Help us plan and test and experiment with ways and means of meeting the requirements and fulfilling the needs. And help us figure the cost. Again we will have to fight down our pet ideas about means, materials and organization structure best suited to supply the services needed, unless, of course, our own ideas survive the rigorous objective tests to which all ideas should be submitted.

We remember that the organic strength of a plan is determined by its built-in values. A strong plan goes into details with scientific care and then weaves the details into a whole fabric which will withstand searching scrutiny and criticism.

Resistances Dissolve as They Arise

Our plans must be publicized so they must not only have built-in values but they must have systematic arrangement which will permit of clear statements of those values. When values are well balanced and clear-cut there is a demand to hear about them. To tell about them effectively resolves merely to a dignified technique of expression. Again publicity exploits the work we do, the plans being shaped and tested, the service means and mechanisms which have passed the tests, and all the work that is so far fully organized. Complete exposition of our situation and progress and perfect candor will encourage criticisms but in so doing it will educate and win active support and cooperation in our planning.

The development within our hospital is unique in that it is not calculated to outflank the natural resistances that ordinarily build up against promotion and development of any kind. These resistances are being dissolved as they arise. In fact, if

the development ideas have been correctly formulated, resistance to them does not arise because they are not our ideas presented to other men of the city with a plea for acceptance; they are the ideas of the men to whom we present the development.

We see in this the invincibility of an idea scientifically conceived and tested, and we begin to see that there are equations in human relations that are just as scientifically balanced as the equations of physics and chemistry. Perhaps in this we begin to see a definition of the scientific method. May it not almost entirely resolve to detachment of self? More than that, elimination of self and the sense of proprietorship, even of ideas? The content of an idea, is that so important? At most it is plastic. Objective tests will show that it fluctuates—that it is valuable in some situations, of little practical use in others, and nil sometimes. Method of conceiving an idea—is not that the thing?

Citizen at Last Learns for What He Is Paying

About now someone is going to say, "Quite an interesting procedure perhaps, but who pays the bill?" This question is meant to stop us cold in our tracks. But we have learned by now that sound fund-raising methods are those which integrate our efforts to obtain support and funds for development with the development itself. Fund-raising efforts also become incidental to the development program and organic with it. They are not really successful if they are isolated and spasmodic affairs. So we have a plain answer to the question.

Our responsible citizen is going to pay the bill, of course. He knew that he was going to pay the bill the first day we talked to him about the work of the hospital. The only difference is that now he has a fairly good idea of what he is paying for. He never knew before.

Moreover, we have been honest with him. We have not high pressured him or coerced him or tried to shame him into paying the bill. We have not acted like hangdog beggars or any other species of pious faced hypocrites who pretend that they are martyrs in the cause of service to humanity. We are just manufacturers of a good product—one for which there is a substantial demand. And throughout we have done our work in such a way that we have dignified it and our offices.

Our responsible citizen does not want something for nothing. He intends to pay for what he gets. Especially since he told us what he needs and wants and thinks he ought to have. He helped us to design the product. He is as proud of it as we are—it is his product, too. In reality, he just hired us to help make it and deliver it at his door.

An Operating Pavilion Modern in Feeling and Equipment

By ANTON SKISLEWICZ, B.ARCH.

Architect, Miami, Fla.

RECENTLY opened for occupancy, the operating pavilion of the James M. Jackson Memorial Hospital, Miami, Fla., culminates years of effort to secure adequate operating facilities and relieve congestion in an expanding hospital organization.

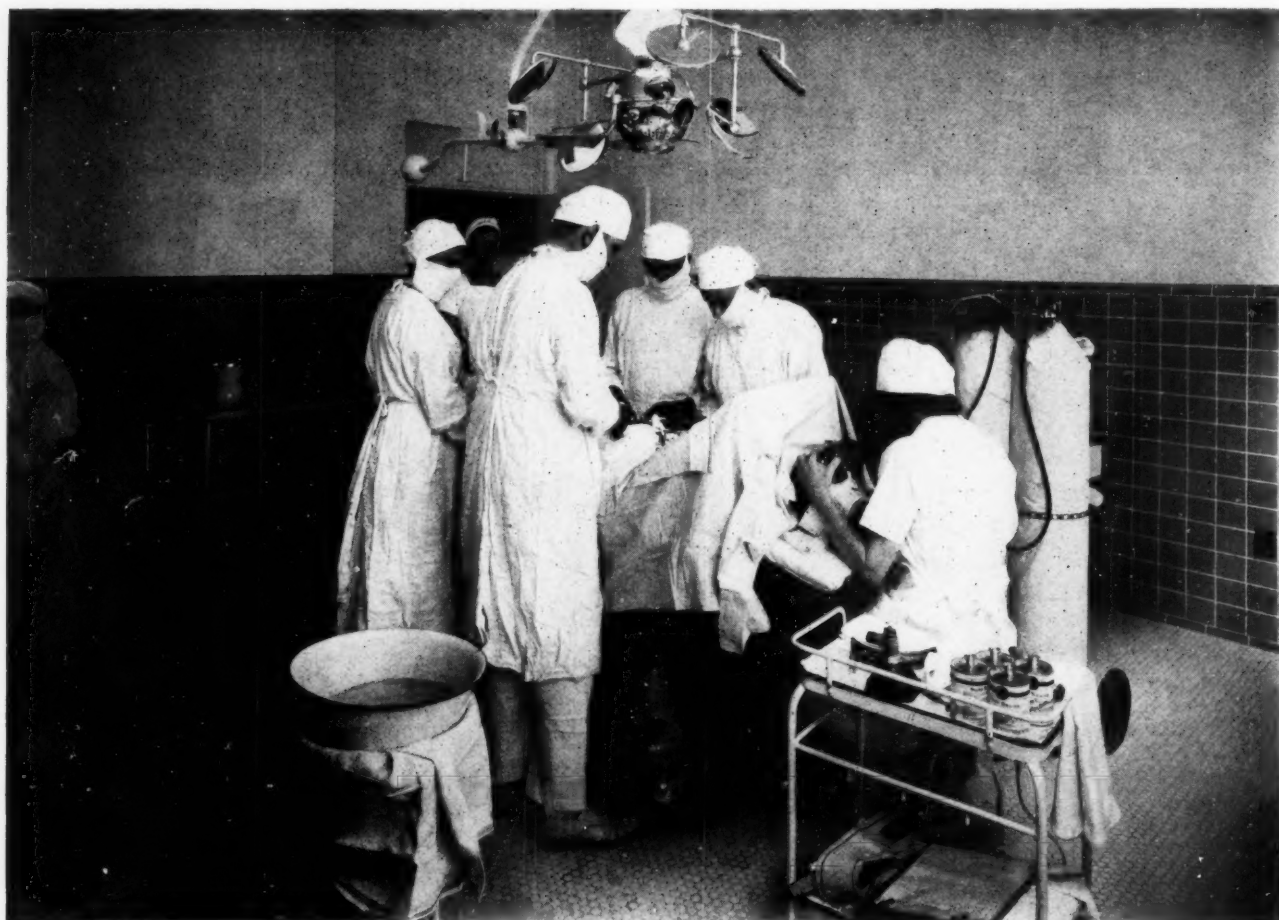
The erection of this pavilion terminates a carefully planned financial and building operation involving an expenditure of more than \$45,000. The building was erected by organized labor. The men accepted, in lieu of cash, nonnegotiable hospital scrip to be used for hospitalization by themselves or members of their families.

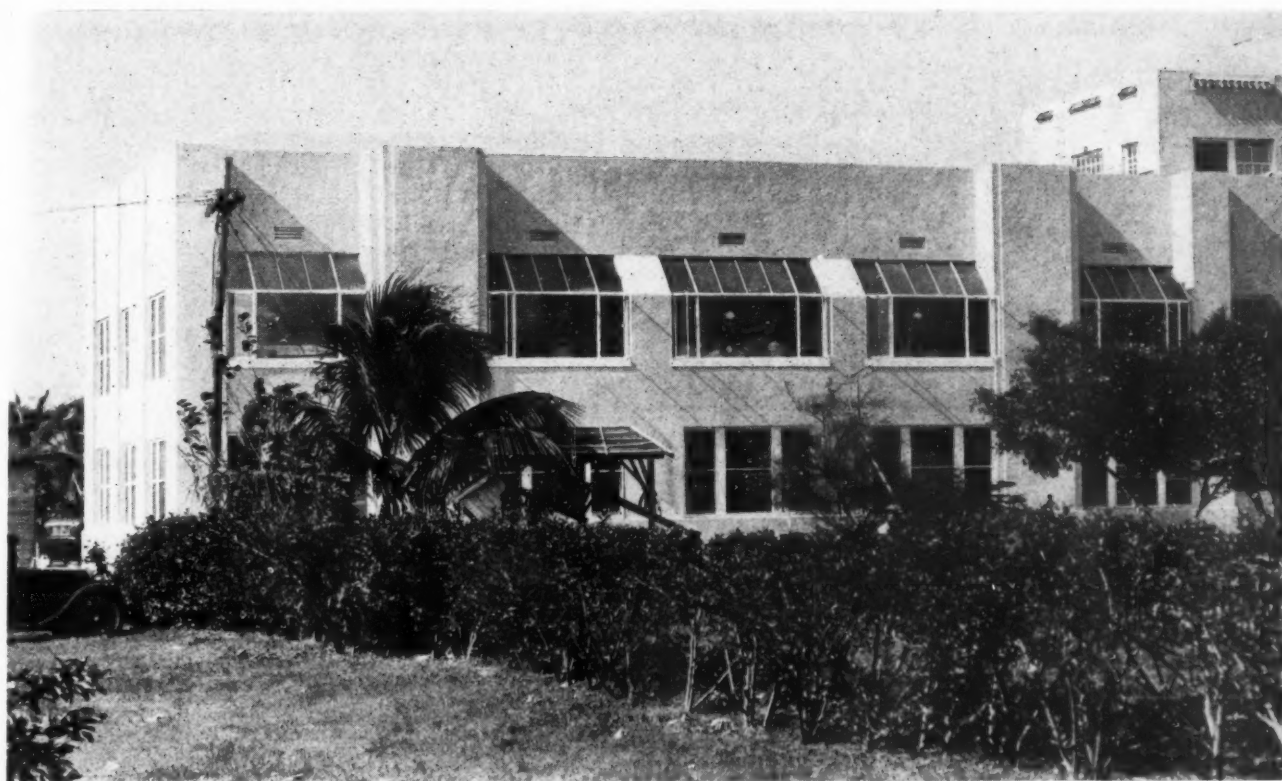
Placed between and perpendicular to the long axis from the private and public ward building,

the new operating pavilion connects these two buildings and the opposite ward building with covered passageways. For the most part, the pavilion is two stories high, conforming to the story height in the adjoining buildings.

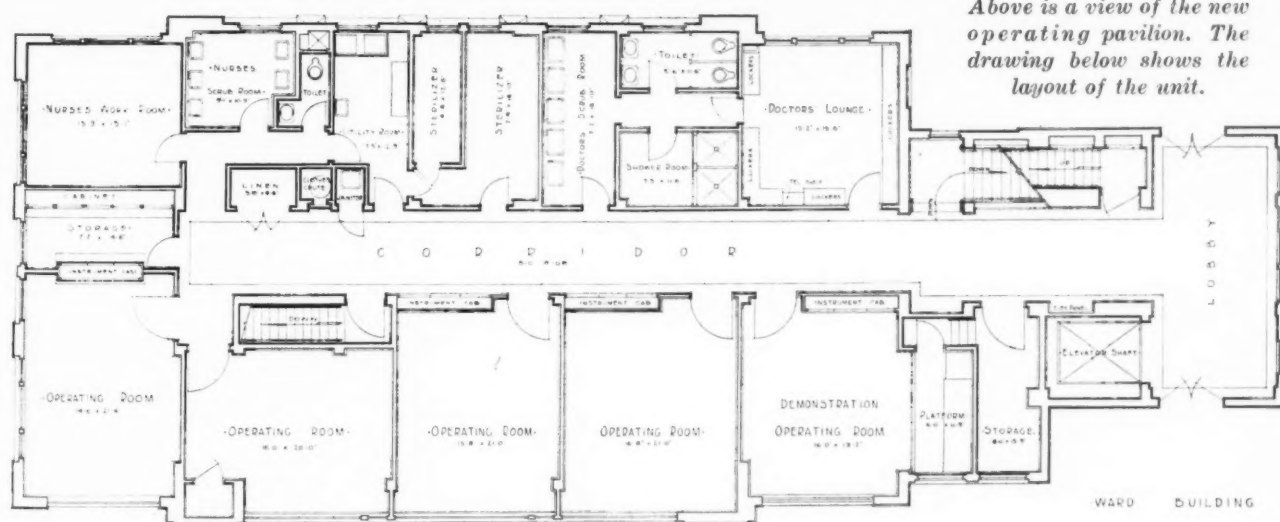
The structural frame of the pavilion is of reinforced concrete, with concrete block wall enclosures on the exterior and gypsum block partitions in the interior. The floor slabs are of reinforced concrete of pan construction. The exterior is stuccoed to match in texture and color the standard wall finish of the hospital.

It was necessary to design the main building in simple forms and plain surfaces with clear, distinct outlines, because the budget demanded strict





Above is a view of the new operating pavilion. The drawing below shows the layout of the unit.



economy. On points of transition only has the prevalent feeling of the adjoining buildings been recalled. This departure in design emphasizes the functional purposes of the building.

In the building a number of desirable features have been emphasized, such as the elimination of crossings in routing around, to and from a central operating table of modern design; the installation of shadowless light distribution fixtures; the arrangement of all accessories in wall recesses, easily accessible and placed according to their major usefulness; the elimination of all dust collecting protrusions, through the use of half-round metal trims at doors and windows, and air con-

ditioning by mechanical control of temperature and humidity.

A central gas station supplies all operating rooms with nitrous oxide, carbon dioxide and oxygen. The vacuum and compressed air systems operate through copper tubing built into the walls. There is a call system, both buzz and signal, communicating with the stenographer's desk in the front lobby.

To procure the best natural light all operating rooms have northern exposures.

Since its occupancy the operating pavilion has been visited by medical men of wide experience, all of whom commend many of its features.

Someone Has Asked—

What Are the Housekeeper's Specific Duties?

There is no generally adopted standard covering housekeeping methods. Some institutions employ a trained woman who is responsible for the cleaning and orderly janitorial upkeep of the whole plant. In other instances the housekeeper is responsible only for the cleanliness of living quarters of personnel housed within the institution.

In the first instance the housekeeper is usually responsible to the superintendent. Sometimes she answers to the director of nursing. In smaller institutions an assistant to the director of nursing may be designated as housekeeper and in still other instances ward head nurses are responsible for this work. When one person is responsible for housekeeping she has the following duties:

She engages all janitorial help and is responsible for their work. She makes daily inspections of all rooms, wards and living quarters. She receives instructions directly from the superintendent. She has cooperative relations with other department heads but receives no instructions from them. She is responsible for the requisitioning or purchasing of janitorial supplies and for the general economies possible in this department. She is one of the institution's recognized department heads.

When alterations of this plan are in force there may be a corresponding rearrangement of responsibilities and duties. The housekeeper usually has no authority in any instance over persons other than those performing janitorial work.

How Long Should a Children's Hospital Preserve X-Ray Films?

This question is practical but it cannot be answered decisively. There seems to be no reason why an x-ray plate of a child's chest should be preserved for a shorter time than that of an adult.

Most institutions do not destroy any films until twelve months after taking. In others this period is two years or more. Some hospitals preserve for at least five years films of accident or negligence cases or those of patients

who are likely to be involved in legal controversies. Sometimes the period set by law beyond which suit may not be brought determines the time of storage of films of liability cases. These general considerations appear to apply to x-ray films of both adults and children.

If storage space within the x-ray department is limited, the long-time preservation of films may be accomplished in an adjoining building or better still in one completely detached from the hospital proper. Permanent storage of films seems to be ideal but obviously this is not always possible.

Can the Coroner Forbid a Postmortem Examination?

The local coroner frequently has but little vision or understanding of the necessity or even the advisability of performing postmortem examinations. For this reason alone he is usually far from cooperative. Again, he frequently complies with the request of friends and relatives that a postmortem be not held, believing that this procedure may react to his interest when next he runs for office. In some instances coroners openly advise relatives against permitting postmortem studies. In other instances undertakers intercede with the coroner to prevent postmortem examinations being held and the hospital finds itself confronted with a disinclination on the part of the family and open opposition on the part of the undertaker and the coroner.

A report is made by the hospital to the coroner of patients dying before twenty-four hours have been spent in the institution. This is frequently a mere formality when there is no suspicion of foul play. The hospital simply demonstrates thereby its desire to obey the law in spirit as well as in letter. As soon as the coroner has officially released the body, the relatives may permit or refuse a postmortem study. If malpractice or foul play is suspected, the coroner may decide to perform the necropsy himself. This

he has a legal right to do. After he has released the body the family still has a right to permit necropsy. In other words, before a coroner's inquest or before a formal release of the body, the coroner may forbid a postmortem examination but once these steps have been taken the coroner has no more legal right to decide what shall be done with the body of a deceased person than had the death not been reported to him at all.

The hospital, understanding its rights in the matter, frequently is able to secure permission for a number of postmortem examinations which it otherwise would lose. If an institution has in its possession a signed permission for a necropsy before the death is reported to the coroner, it is best to retain this contract and act upon it only as soon as the coroner has officially announced the release of the body.

It is best for the hospital to have no conflict with the coroner but in instances where this officer is uncooperative, the hospital should have the courage to stand upon its rights.

Should Claim Adjusters Be Allowed Access to Patients or Records?

It is a common practice for agents of insurance companies to seek contact with hospital patients who have suffered injuries in accidents. When such an interview is granted by an unsuspecting executive, a settlement agreement may be made and damage claims may actually be paid while the hospital is unable to collect its fee for the service rendered. Often when claim agents are detected brazenly copying hospital charts and reprimanded for doing so they feign ignorance of rules.

Such an occurrence is most unfair to the institution and it is a despicable act on the part of the patient. It is unexplainable why patients and others who deal with the hospital should endeavor to trick such a worthy charity. The executive's only efficient defense in combatting this devious practice is to forbid such agents access to patients except when a representative of the institution is present. Only when an agent has been found to be trustworthy should this rule be relaxed.

If you have any questions to ask, the editor will be glad to discuss these in a forthcoming issue

A Tramp Abroad— in the Hospital Field

Part V—Germany

By A. G. STEPHENSON

Stephenson & Meldrum, Architects, Melbourne, Australia

GERMANY'S stringent financial condition is strongly evidenced in Dresden. The city has a population of three quarters of a million and three principal hospitals. One of these, the Krankenhaus Johannstadt, completed only four years ago with a bed capacity of 1,500, has been closed. The two other state hospitals have provided such accommodation for the acutely ill as is possible and, as for the rest—well, they must get along just as well as they can. Often, one is told in Germany, people just cannot afford to be ill. They go to a hospital now as a last resort, and this fact is causing much uneasiness to the health authorities and they are at a loss to know how to meet the situation.

The chief of the nursing profession and of the principal training school for nurses in Dresden is a charming lady of the aristocracy of Dresden — Dr. Fraulein Von Abendroth. She speaks English as easily, almost, as her mother tongue and spent many hours discussing with me the social problems of Germany. One of her ambitions was to develop the training school for nurses at the Johannstadt Hospital and the hospital's closing has caused unhappiness to its sponsors.

Nursing Students Live in "Families"

The organization of this school, which was probably the leading one in Germany, is interesting. One hundred and sixty-eight nurses are accepted in the school, and for the whole period of their training are divided into seven families of twenty-four members each. The head of each family is a sister, who is responsible in part for the discipline



An apartment house in Stuttgart.

and training of her "children." These family groups are accommodated in eight student bedrooms of three beds each, a sister's bedroom and sitting room, and a general sitting room. The bedrooms are large with recesses for the beds. Each is furnished with three wardrobes, a wide dressing table, three little steel lockers for spare morsels of food and fruit, and three quaintly designed bedside tables and chests of drawers combined.

In the students' rooms there are no lavatories, but each family in the precincts of its "home" has three showers and one tub. In the same section are individual wash basins for each nurse separated from one another by a plate glass partition. There is also a room for washing the hair and it is equipped with drying machines; provision is also made for minor laundry work. The nurses' home is fitted up with a large gymnasium, for training in gymnastics is part of the nursing curriculum. So also is a course in massage, and cubicles are provided for this purpose off the gymnasium.



*Rainy weather at the
old market place,
Nürnberg.*

Nurses coming off duty must go to the central wash room on the ground floor where there are 168 basins, all partitioned in the manner mentioned; sisters coming off quarantine duty enter a small bathroom where they change into off duty dress.

Rooms for visitors are provided on the ground floor; there seem to be few if any restrictions about taking the guests into the "family" sitting rooms.

In the whole of this large nurses' home, only two house maids and three kitchen maids are employed. Junior nurses do all cleaning except corridor floors and large areas where polishing is to be done. They do the serving at mealtime and the dishwashing except of the kitchen utensils.

There are no separate dining rooms for the sisters but they have separate tables in the main dining room. Tables accommodate six. Tables in the kitchens and in all cooking demonstration rooms are fitted with two small rubber tired casters so that they may be wheeled around easily and, when set, will not move.

Prefer Acting and Music to the Dance

Demonstration rooms, classrooms, lecture hall, large general kitchen and diet kitchen for teaching purposes are well fitted up. The assembly hall is one of the finest I have seen anywhere.

German girls do not dance much but are fond of acting and singing and of music. Consequently, the assembly hall is fitted up with a stage, drop screen, a grill, drop curtains, footlights and spot lights. It is here that most of their recreation time is spent. One often sees these young women practicing their songs or reciting their pieces to an imaginary audience. I think what makes these halls so attractive are the beautiful effects that

the Germans obtain from their lighting fixtures.

In the nurses' homes on the Continent, each girl is encouraged to express her own individuality in her room. They are not like hotel bedrooms, but are simply furnished. The furniture is quaintly designed as a rule and very good. The sisters' rooms often remain their home for years and frequently they provide their own furniture and surround themselves with their "household gods." Their rooms look well lived in and comfortable.

Nurses Give Much Time to Sports

This home is built on the central courtyard principle and the courts are used as inner parade grounds or for sun bathing and outdoor meals. Fraulein Von Abendroth has decided views on the value of sports and wholesome exercise. She says that, amongst other things, it seems to reduce conceit, develops a spirit of friendly rivalry and, in fact, makes the girls better fitted for their jobs. She does not think a nurse should be given any false ideas by theoretical training, which after all can be only of a superficial nature. She believes in theory where it applies to nursing only, but not where it would encourage the nurse to try to teach the doctor his job.

The modern German method of planning for sick children is splendidly exemplified in the Kinderspital. This is a new section of the Johannstadt Krankenhaus and houses 200 children.

When patients are drafted into the hospital from the polyclinic, they are first taken to the observation department on the ground floor, which is composed of a series of cubicles glassed to the ceilings. There are twenty large cubicles and twenty small ones. Each is fitted with high standing baths, a slop hopper and sink and has a door opening on

to an open air terrace. The small cubicles are for babies and very young children, and these are fitted with heated bathing slabs.

Special nursing technique is observed in this ward and patients are retained here until their complaint is definitely diagnosed. This system is flexible and, if there is no doubt about the child's sickness, he is sent directly upon admittance to the most suitable ward.

One Visiting Hour a Week Through Glass

Two special rooms are provided for mothers in the observation section in case the little one is very sick, but it is on these cases alone that mothers are allowed such privileges. There is a strict rule rigidly enforced that neither parent nor visitor may see a child except from between 2 to 3 o'clock on a Sunday and then only from the terrace outside the ward. The terrace walls are mostly glass and it is through this glass screen that the mother may see her child. They assert at this hospital, and it would appear with good reason, that since the cubicle system has been enforced and rigid discipline of visiting hours maintained and since the use of the open air terraces was begun, the average bed stay of the patient has been reduced by eight days and cross infection has been practically eliminated.

Every ward and cubicle of the whole hospital opens on to open terraces and this open air treatment is said to prove of great value in all forms of sickness. The little patients practically live in the open on fine days; they are protected from the sun's fierce glare only by colored sun shades that are fixed to each bed.

The method of dressing the youngsters is interesting for, instead of having a standard uniform, each child is dressed in a tunic or night dress to suit his coloring. It is most refreshing to see youngsters sitting up in bed or playing about in the big convalescent nurseries dressed in their nicely cut, gay colored rompers.

The nursing personnel at this hospital is typical of most children's hospitals in Germany. Here there is one nurse to four patients and one supervising sister to each twenty-five patients. That is less than is the custom for children's hospitals in America, but I can assure you that, to a layman, their extreme care of the patient and their generous unselfish service to the little ones leave nothing to be desired.

Leipzig is a large industrial city and is blessed with several new hospitals. It is also justly proud of the finest housing develop-

ment in all Germany. Then there are the great new markets, public baths and a war memorial that is so impressive that, even now as I write, I am conscious of its frowning solemnity. Leipzig's exhibition ground, of course, is famous all over Europe and the United States for its fairs.

Yet, with all these signs of prosperity, this beautiful city of 800,000 is in dire financial distress. As in all manufacturing cities, its toll of unemployed is enormous and great numbers of women are forced by circumstance to try to eke out an existence on the street.

A Famous Skin Clinic

The enormous hospital of St. Jacob in Leipzig has over 2,000 beds. It is the main hospital of the state of Saxony and, like all their institutions, is extremely well run. It is overcrowded and is an old hospital except for its dermatological clinic and hospital for skin and venereal diseases. The latter occupies a separate building connected with the main hospital by a long tunnel under the road and contains 400 beds. It is a part of the university



A young patient at Humanitas Hospital, Leipzig, who acted as interpreter for the author.

medical school. The building is similar in some respects to the new hospital built for the same purpose in Vienna, the Wilhelmina Krankenhaus, which I have already touched on. Strangely enough, Professor Rille, the director of the hospital, is an Austrian.

Here is a particularly well equipped laboratory for all forms of research and a large museum and library containing many thousands of exact reproductions in wax of the ravages of various forms of diseases of the skin. This has been a strong feature of the professor's instruction in his special classes and it is interesting to note that this method of reproduction is being developed extensively throughout the Continent. Light treatment is extensively used, and in particular the Finsen lamps invented in Copenhagen. The treatment rooms are large with dressing cubicles opening on to them and with a bath department in the suite so that each patient may be bathed after treatment. There is an average daily attendance of ambulatory cases to this clinic alone of more than 200 patients.

The Professor's Face Gets Red

The professor explained the way he had had the sixth and top floor planned and took me outside into the street so that I might study the elevation. As we went out he was telling how he had had the windows raised well above the floor on that story, for it was used for the periodic examination of prostitutes. These young women, he said, were given to skylarking and hanging out over the street. When he had finished telling how all this behavior had been stopped, we looked up and there at almost every one of the dozens of windows on the enormous façade were young women in their striped hospital gowns hanging over the ledges.

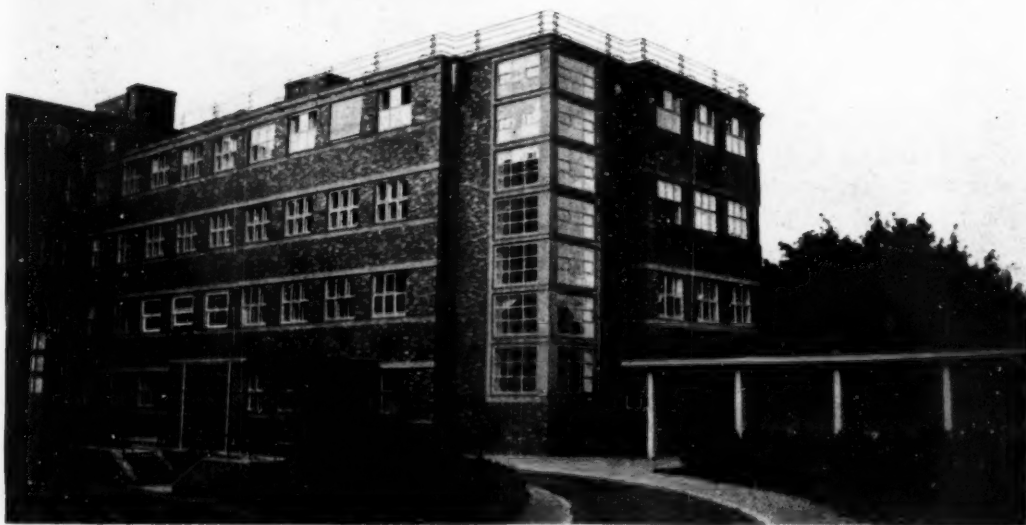
After that, I didn't see the professor's heels for dust, and within a minute, all the jovial faces had disappeared. This floor is practically without partitions but is divided into many cubicles by heavy duck curtains.

Farm Training at Hospital for Crippled Children

The Humanitas Hospital, another state institution, is for crippled children; it has accommodations for 200 patients. Extremely well planned, it has as principal features huge central playrooms on each floor and extensive work shops for occupational training, including looms for all forms of weaving, turning and lathe shops, and bootmaking shops. In a well equipped chemical laboratory quite advanced instruction is given the patients. The corridor walls are all fitted with railings as aids to the youngsters in walking; the corridor color scheme is deep red and dark yellow. Throughout the hospital, the colors used are strong but they are harmonious and a delight to see.

On the top floor, which is terraced back, are housed the children with tuberculous limbs and spines. The walls facing the north are enclosed with huge windows, 12 feet long and 7½ feet high; these can be thrown up and the beds moved out into the sun. The necessary plaster rooms, operating rooms and the x-ray apparatus are on this floor but are entirely disconnected from the wards. In the ceiling of the main corridor, a traveling block and sling is fitted for exercising the youngsters and teaching them to walk in their frames and plaster splints.

Just as soon as they are able, the older boys who come from farming districts are trained in farm work. There are cows and horses, bees and fowls on the little farm, and even a very old Ford car.



The patients' entrance to Frauenklinik at Stettin in Prussia.

Why the Executive Needs to Know Something About Medical Procedures *

THE most recent survey of the institutional field conducted by the American Medical Association reveals that 6,437 hospitals accommodating 1,027,046 beds serve the population of the United States and Canada.

Forty per cent of these hospitals are administered by nurses, 36 per cent by physicians and 24 per cent by laymen. These figures recall the ancient and trivial controversy as to whether those who possess medical or nursing degrees exceed in administrative efficiency those who are trained more or less thoroughly in the ways of business.

More than a knowledge of medical science and practice or skill in business matters are required to make a good hospital executive. Given a knowledge of medicine coupled with an equal degree of business acumen, a physician superintendent should be able to administer a hospital more successfully than one who knows only the routine of business. On the other hand, there are many lay administrators who are without question rendering a more complete service than some physicians who possess a knowledge of medicine but lack good business judgment.

More Than a Casual Observer

It is impossible to paint the ideal attitude of the administrator—be he physician, nurse or layman—toward the medical practitioner and practices in the hospital. Certainly, however, he should be more than a mildly interested observer. He should be familiar with modern methods and apparatus employed in the treatment of the sick. He should not meddle with the prerogatives of staff physicians nor should he permit himself to become unduly sentimental.

What then should the superintendent know concerning the scientific work of the hospital? Since he is, either actually or through a second person, the purchasing agent for drugs he should be

The hospital administrator should not be tempted to meddle with the physician's prerogatives. The intelligent executive, however, may demonstrate his administrative acumen by always exhibiting an attitude of informed interest. By so doing he may be able to limit useless expenditures, and hence to increase purchases of some more necessary therapeutic agents

familiar with the methods by which these remedies act and those modern developments that have brought into existence specifics for the treatment of certain diseases. The nature of infection and methods of producing immunity by the use of anti-toxins and vaccines should not be beyond his ken. The reason underlying immunization against tetanus when puncture wounds are presented for treatment in the accident ward and a smattering of data relative to the tetanus bacillus itself should interest him.

When he is requested to purchase Schick and Dick material for use in the pediatric department or in protecting the health of a new class of probationers, the superintendent should know the connection of these tests with the discovery of the need of immunization against diphtheria and scarlet fever. No superintendent can be intelligently cooperative with the efforts of the school for nurses to safeguard the health of its members unless he is informed of recent advances in preventive medicine.

When a rush order for perfringens serum reaches his desk from the surgical ward, the superintendent will be less likely to withhold his signature if he knows something of the deadliness of gas bacillus gangrene for which the remedy is requested. When a number of children in a community are bitten by a rabid dog and threatened with hydrophobia, the superintendent, understanding the hopelessness of the disease once it has devel-

*Practical Administrative Problems Series.

oped and knowing the efficacy of the Pasteur treatment if employed promptly, will allow no time to be wasted in securing the remedy. When a request for arsenic or bismuth compounds to be employed in the treatment of venereal disease is forwarded to him, the superintendent who knows the specificity of these drugs in this condition will not hesitate to expend the necessary sum of money to secure them promptly.

Many an administrator frowns upon requests for biologicals and agents employed in the discovery and treatment of allergic conditions. In these stressful economic times, most institutions have rightfully concluded that it is rarely necessary to purchase other than United States Pharmacopœia and National Formulary drugs for the use of ward patients. This rule must be broken if some unusual situation exists. If the executive realizes that such an inclusive list as is represented by these two volumes is usually amply sufficient to treat most conditions he will scan more critically bills presented for the purchase of proprietary or semi-proprietary preparations. One reliable preparation of digitalis for hypodermic use and one liquid and one dry preparation for oral use should be sufficient. Recently it was discovered in one institution that almost a score of varieties of expensive digitalis preparations were being employed in the treatment of ward patients, much to their economic disadvantage. A superintendent who knows something about the nature of digitalis would never permit this situation to exist.

The superintendent who is convinced that few specifics for disease are available and that there are many drugs which are but feeble assistants to nature in bringing about recovery from disease will be less likely to approve without question a drug requisition solely because the physician has ordered it.

Must Keep Up on New Methods of Treatment

What should the superintendent know about the therapeutic methods employed in the specialty departments of his institution? If he understands that artificial production of fever is one of the newer developments in physical therapy and that cerebrospinal lues, certain forms of arthritis and some stages of gonococcal infection yield rather promptly to this treatment, he will not be shocked at a request for this expensive type of apparatus. He should be convinced that the use of water, heat and electricity in the treatment of disease is fast being removed from the hands of the quack and is rapidly assuming its proper place in the hospital's armamentarium.

One frequently observes in the storerooms of hospitals much apparatus—probably purchased at

the request of overzealous and enthusiastic physicians—that is now worthless and that at no time was sufficiently used to justify its purchase. Such expenditures could be avoided if the lay superintendent endeavored to learn for himself concerning the probabilities of new and expensive equipment actually proving efficient in the treatment of the sick. His refusal to purchase such equipment would be only good business sense.

In regard to the x-ray department, the executive cannot be expected to possess more than a fund of general information relative to the procedures necessary to produce good pictures or to provide adequate treatment. Yet he should know what types of films are inflammable or explosive and the methods of safeguarding the property of the institution and the lives of its patients from such accidents. Many disastrous accidents from the explosion of cellulose films could have been prevented if the executive had been really alert to the finer details and responsibilities of his position and had left less to the discretion of professionally trained persons who were either careless or uninformed.

Precaution Against Accidents

The superintendent should not permit the use of anesthetics in the roentgen ray department nor should he be blind to the possibilities of injury to employees because of exposed electric wiring or careless or shoddy installation. He should understand that the use of x-ray and radium in the treatment of malignancy offers much toward palliation if not actual cure. Knowing this, he can be convinced of the necessity of providing a proper deep therapy apparatus or of the fallacy of endeavoring properly to treat malignancy with a nine-inch machine. When he is convinced that the moving of certain types of fractures is inexpedient or that the transportation of a pneumonia patient to the x-ray department is dangerous, he will not hesitate to recommend to his board the speedy purchase of a portable x-ray machine.

Realizing the danger to patients of improperly handled radium, the superintendent will take every necessary step to avoid such catastrophes as the occurrence of extensive radium burns by providing proper personnel and physical equipment as requested and outlined by the physician administering the treatment. He will not be content with slipshod methods in the protection of this valuable element from theft or loss through carelessness.

Most hospitals possess electrocardiographic departments. The superintendent will be less likely to view with alarm a rising expense item from this department when he realizes the increasing usefulness to the clinician and his patient of the information thus provided. He will view with sympathy

a recommendation that all preoperative cases be electrocardiographed and will be less likely to endeavor to interpret the value of this department to the hospital in terms of dollars and cents as expressed in income figures. Moreover, once convinced of the practical usefulness of a properly conducted cardiologic department he will either see that a portable machine is provided for studying the heart action of patients too ill to be transported or provide convenient outlets for making these records throughout the wards and rooms of the institution.

What should the superintendent know in regard to the efficacy of oxygen in the treatment of pneumonia or other asphyxial states? Surely it would be of interest for him to realize that the atmosphere contains approximately 18 per cent of oxygen and that in a properly constructed oxygen tent this concentration can be increased almost at will. If he knows that a state of asphyxia persisting for any length of time is likely to work permanent damage to nervous tissues and if he understands the actual life saving possibilities of hyperoxygenation he will be more sympathetic with a request for a sufficient number of apparatuses to meet the needs of all patients requiring this treatment.

The basal metabolic test is another common procedure practiced in most hospitals. It is a matter of almost general understanding that the machine employed for this purpose is capable of measuring the rapidity of the process of the building up and the tearing down of the body in terms of oxygen consumed. It should be of interest to all executives to know that in such conditions as exophthalmic goiter, febrile states, certain blood diseases and in some nervous conditions such as paralysis agitans the normal reading of from plus ten to minus ten is sometimes greatly elevated, and that in cer-

tain other diseases such as thyroid deficiency and in certain wasting states without fever this reading may be much depressed.

A superintendent was recently requested to purchase an electric clock with a phosphorescent face for use in the urologic clinic. Had he known that the time of elimination of the test dye from either kidney determines the operator's opinion as to the presence or absence of disease and that this study is made in a darkened room while a cystoscope is in place, he would have understood why it was necessary to have at hand a timepiece that could be read in the dark.

Most hospital executives appreciate the necessity for a classification of the end results of treatment in the surgical department. Without this information reports from this department as to the cause of a patient's death would be all but useless. Knowing that such a classification is possible, the superintendent will be less likely to accept complacently a statement as to the number of surgical deaths during the month without inquiring as to whether they were due to the patient's disease, to a catastrophe or to an error in judgment, technique or diagnosis. He will realize the dangers underlying indiscriminate admission of patients suffering with incomplete abortions. He will understand the hazards to which patients are exposed by the hurried surgeon. He will realize the possibility of the standardization of surgical technique.

It is to the interest of all concerned for the superintendent to become generally aware of the basic facts relative to the scientific work of the hospital, to keep a mind alert to new developments and an attitude that never discourages but always encourages and stimulates others to progress. Such a mental outlook on the hospital's scientific endeavors is a necessary possession of an executive if he is successfully to administer the hospital.

X-Ray Work in Small Hospital Should Be Simple

Small hospitals should confine their x-ray work to fractures and emergencies, in the opinion of a committee of the Canadian Hospital Council which recently concluded an extensive study of the problems that confront small hospitals.

Such limited service does not require expensive equipment and its operation can be easily mastered by a local doctor or the superintendent.

To undertake more extensive work brings technical difficulties and problems of interpretation. An x-ray picture that is improperly taken or wrongly interpreted is worse than none at all, it is pointed out.

The Canadian committee strongly condemns the common

practice of x-ray installations too elaborate for the needs of the hospitals, in which one of the nurses who "picked up" the technique operates the apparatus and each doctor interprets his own plates.

If it is considered necessary to install an x-ray plant, the hospital should send some member of its medical or nursing staff away for a sufficient period to learn the technique of operation.

In some Canadian towns not widely separated, hospitals have arranged for a part-time traveling radiologic director. This seems to work out well in adjacent towns and is a plan that will probably be more widely developed.

One member of the committee suggests that prices in small towns should not be as high as in larger hospitals where better equipment, better qualified technicians and the diagnoses and services of an expert radiologist are available. This idea is worthy of consideration.

PRINCETON Methodist Hospital, Princeton, Ind., was built by three local doctors in 1906. Two of these doctors died soon after the building was erected. The surviving owner endeavored to operate the hospital but after four years was compelled to close it because of unsatisfactory earnings.

The building was closed until 1917. During that year in connection with a drive for college funds that was being conducted in the county by a Methodist organization, sufficient funds were raised to purchase and equip the hospital. An agreement was then made with the Methodist Episcopal Hospital of Indianapolis whereby that organization was to take over the local hospital and operate it as a branch. Thus the Princeton institution became the first branch of the Methodist Episcopal Hospital of Indianapolis. A local board was appointed, and it operated the institution.

It has been a source of pride to the local board that this hospital has been operated continuously since 1917 without financial assistance from the Methodist organization. The methods used in securing sufficient funds to operate, purchase equipment and make additions might be of interest to other boards operating similar hospitals and for that reason this article has been prepared.

Princeton Methodist Hospital is a small institution of thirty-five beds. It is the only hospital in Gibson County, the population of which is approximately thirty thousand. The first step was to convince the residents of the county that if they wanted this hospital operated and maintained the necessary funds must come from revenue derived from patients and any deficit must be met by the public; that the local hospital could not expect any revenue from outside sources.

County Association Formed

In the early years when the local board operated this hospital there was a deficit which was met by an organized drive for funds during November of each year. The largest amount raised in any one of these years was \$3,750. At various times it was suggested that this was not a satisfactory way of raising funds for the reason that the persons who contributed were the same persons who were solicited on all other drives; that the people who were not giving were the people who should give; that funds should be raised to meet this deficit by taxation. The objection to raising funds by taxation was that it would be illegal for the county to appropriate funds for the hospital for the reason that it was a denominational institution. To meet

Keeping Out of the Red

By MARY ELMA THOMPSON

Superintendent,
Princeton Methodist Hospital,
Princeton, Ind.

this objection the local committee formed a non-partisan and nonsectarian organization known as the Gibson County Hospital Association for the purpose of operating the hospital.

This association then entered into a contract to operate and maintain the hospital with Gibson County and the county appropriated the sum of \$3,500 to be used by the hospital association for the payment of unpaid bills due the association.

How the Money Is Spent

This money was not to be used to take care of the township poor but was to be used by the hospital association to take care of persons who were unable to pay in a reasonable time after hospitalization. If any of the bills were later paid, the hospital credited the account with the amount paid.

When this appropriation was first secured and for several years thereafter the unpaid bills due the hospital each year amounted in the aggregate to about \$7,000. The hospital association realized that this was entirely too much and other steps would have to be taken to reduce the amount of unpaid bills.

The matter of finances was brought before the medical staff and a rule was adopted that if any question arises about paying the hospital bill, the doctor should discuss the matter with the patient or his family. If there is no solution the patient or some member of his family must come to the hospital to make financial arrangements before admission. This rule has been satisfactory for we find that a patient with any chronic complaint who really needs hospitalization will be able to find some means of financing the legitimate hospital expense. Staff doctors seldom bring a patient

Other small hospitals can profit by the story of Princeton Methodist Hospital, which enjoys the respect and support of its community. The institution's financial policy enables it to apply donations, gifts and a part of its earnings for new equipment and improvement. Few persons now leave Gibson County for hospitalization

for admission to the hospital until financial arrangements have been made for the hospital expense, unless we have agreed to admit the patient as an indigent case.

If our staff doctors say that a case is an emergency and the patient must be cared for at once we take care of the patient without hesitancy. We never question the financial side of emergency cases and the same service is given to the patient as if financial arrangements had been made.

Obstetrical Patients Pay in Advance

Another procedure we have adopted is the payment in advance or at the time of admission of the cost of hospital service rendered obstetrical patients. Again, in cases of emergency this rule is not enforced. It is up to the staff doctor to say that an emergency does exist.

Each year, on the day before Thanksgiving, Princeton Methodist Hospital conducts a drive for linens, fruits, vegetables, jellies—in fact, everything that is used in housekeeping. This drive is popular with our people and each year a large room in the basement is filled with supplies. In fact, we secure more than enough as the result of this one day's drive to supply the hospital with all its canned fruits, vegetables and jellies.

Various community organizations have undertaken to equip, support and maintain rooms in the institution and we have found this practice satisfactory. For instance, a young women's organization equipped and is maintaining the nursery, furnishing all equipment and supplies. Another young women's organization equipped, furnished and is maintaining a maternity ward and lying-in room. A considerable expenditure of money is

thereby saved and these departments are unusually well equipped for a small hospital.

A successful hospital cannot be operated unless an efficient up-to-date medical staff cooperates, sells the hospital to the community and convinces all patients that their hospital bills must be paid. The staff should cooperate since the finances of the institution are more important to them than to anyone else. The hospital is their workshop. Here they develop and improve in ability, increase in experience and efficiency and make their reputation. If the hospital is not a financial success it cannot grow and develop and this will handicap staff members in their work.

We have also found it profitable each year to add equipment and to make some substantial improvement in order to increase efficiency of operation. This must be brought to

the notice of the public by publicity, and articles must be written for the newspapers.

The work of standardization carried on by the American College of Surgeons has been a great help to us in the operation of our hospital. Inspectors from this organization have made suggestions for improvement of the operation and efficiency in this institution that have meant much to us. Every suggestion made by these inspectors has been carried out to the advantage of the hospital organization and the medical staff.

The granting by this organization of its certificate of full approval, which was given wide publicity in the community, has convinced our people that their local hospital is as good an institution as they will find. Few persons now leave the county for hospitalization. This adds materially to our yearly earnings.

Voluntary Donations Requested

Four years ago we abandoned our drive for funds by personal solicitation. In November each year we publish an article in the newspapers detailing all improvements made during the past year and requesting voluntary donations. We also mail letters at this time to the list of past donors and request their annual donation. This ordinarily brings in from \$600 to \$1,000 a year.

We have the hearty cooperation of the medical staff and have created a feeling of pride in the community for the hospital and the work that is being done. We have had no trouble with finances and are able to apply donations, gifts and a part of our earnings for new equipment and improvements. We have no debts and current bills are paid by the tenth of the following month.

Editorials

On Reaching Man's Estate

WHEN the first issue of The MODERN HOSPITAL appeared twenty-one years ago this month, conditions in the hospital field were quite different than they are today. The American Hospital Association was a young but growing organization and had not yet established permanent headquarters or engaged a full time executive staff. The American College of Surgeons was not organized until a few months later and, of course, there was no "standardization" program. There were almost no veterans' hospitals and the great growth of other government hospitals was still to come. Nursing education was still a toddling youngster and there were no minimum standards for the curriculum; about one-third of the states had not even begun to register their nurses. The American Dietetic Association was unborn.

Organized community fund-raising efforts for hospitals were almost unknown twenty-one years ago and "the patient of moderate means" had yet to be recognized as a problem. David Lloyd George had just started his health insurance program in England and the subject was new and only vaguely understood in this country. The American Medical Association was still engaged in its fight to stamp out "diploma mills" and to effectuate the recommendations of the monumental Flexner report. There was no list of hospitals approved for internship or for residency in specialties. There were only about two-thirds as many hospitals as now with one-half as many beds. They probably represented a capital investment of less than one billion dollars in buildings and endowment as against approximately four billions today. Although hospitals were increasing rapidly in number, size and importance, there was no adequate journal to report news for them and to act as a clearing house for the formulation and presentation of hospital opinion.

Into this situation stepped Dr. Otho F. Ball and his associate, Dr. John Allan Hornsby, with The MODERN HOSPITAL. Plans for the new publication had been carefully developed over a period of several years, Dr. Ball providing a long experience with the practical problems of medical journalism and Dr. Hornsby supplying an intimate knowledge of hospital administrative problems. The new magazine won immediate approval and acclaim. The

first board of editors was composed of Dr. Henry M. Hurd, Dr. Frederic A. Washburn, Dr. Winford H. Smith, Dr. S. S. Goldwater, Dr. James G. Mumford, Dr. W. L. Babcock and Dr. John A. Hornsby. Although there have been additions and changes among the editorial board in the intervening years, the magazine has continuously had similar editorial direction from representative leaders of the field. Today it is read by progressive hospital administrators not only in the United States and Canada but also in forty-three foreign countries.

As a dignified and effective clearing house for the hospital leaders of North America, The MODERN HOSPITAL has been privileged to take an active part in most of the important experiences of these twenty-one years. It might be interesting to recount a few of them.

The idea of minimum standards of quality for hospitals was early proposed and consistently supported in The MODERN HOSPITAL and the magazine has cooperated with the American College of Surgeons in formulating and developing its standardization program.

When the Catholic hospitals, under the leadership of Father Moulinier, were establishing a national organization the magazine was glad to give them substantial assistance and support.

The magazine consistently pointed out the need of better cooperation among dietitians and when the American Dietetic Association was formed its first president was Miss Lulu Graves who was dietetic editor of The MODERN HOSPITAL.

During the mobilization of men and materials for the World War, the files and field organization of The MODERN HOSPITAL provided a vast amount of information on hospital supplies to the Surgeon General's office. Out of this effort developed The YEAR BOOK as a source of reference on equipment and supplies for the entire hospital field. Following the war, the magazine provided a free placement bureau to aid hospital workers to reenter their chosen profession.

The magazine has consistently refused to accept advertising from business houses that it felt were not willing or able to furnish goods or services of hospital standard. Following the war, for example, it refused advertising of many irresponsible groups selling surgical ligatures, instruments, pharmaceuticals and other "surplus war supplies" of questionable quality.

The establishment of the Hospital Library and Service Bureau was suggested by the magazine and it materially aided in the original development and financing of this bureau.

For some years the company provided a "hospital center" at 22 East Ontario Street, Chicago, in which were housed the American Hospital Asso-

ciation, the Hospital Library and Service Bureau, the National Catholic Welfare Council, the American Association of Hospital Social Workers, as well as the magazine's editorial offices.

With its many contacts among industrial and commercial agencies, The MODERN HOSPITAL has fortunately been able to aid the American Hospital Association in interesting responsible manufacturers in its convention exhibit.

An architectural contest which was sponsored by the magazine elicited an excellent group of designs for small hospitals.

The MODERN HOSPITAL persuaded the National Board of Fire Underwriters to provide an inspection and fire prevention service to hospitals that has greatly reduced hospital fires and fire hazards and incidentally reduced insurance premiums substantially.

The magazine prepared and gave to the hospital field the "Pledge and Creed" and "A Daily Prayer for Hospital Workers."

The magazine joined with others in a determined and successful effort to eliminate the vicious practice by irresponsible and sometimes dishonest firms of promoting fund-raising campaigns on a commission basis.

For some years a magazine known as The NATION'S HEALTH was maintained to correlate endeavor in the hospital and public health fields. This publication was later passed over to the American Public Health Association and combined with its *Journal*.

In The MODERN HOSPITAL was first presented a carefully prepared program for educating the public about hospitals. This has been adopted and partially carried out by the American Hospital Association.

Too much has happened in these twenty-one years to recount all of it but special mention should be made of a few events. Early volumes of the magazine contained two series of articles by hospital leaders on the organization of the hospital — one for large and one for small institutions, and current issues bring another series on the organization of each of the various departments. A reading course for hospital executives appeared monthly during one year. The interrelationships of the hospital administration and the medical staff are now being presented in a series of authoritative articles. Another series presents practical administrative procedures in the hospital. With the cooperation of hospital architects and others, the magazine has recently begun printing critical comments upon architectural plans — the first time, so far as is known, that any magazine has successfully attempted to render this service. Throughout all, the magazine has tried faithfully to adhere

to publishing policies that make a good magazine from a journalistic point of view.

As one reviews these events he feels rather humble. Will it be possible to continue service on the same level of quantity and quality? Certainly the problems of the future are no less challenging than those of the past. And our determination grows with the passing years.

The Challenge of the Future

AS The MODERN HOSPITAL enters upon its majority, it is but natural to speculate about the future. What problems and opportunities face the hospital field and how can this magazine best aid hospitals and the hospital associations to solve the former and take full advantage of the latter? The following summary attempts to hit only the high lights.

Hospital service can be further improved through the provision of sound and effective professional training for administrators. The A. H. A. Institute and the courses at the University of Chicago are excellent as first steps.

Better coordination and integration are needed among the services rendered by the hospitals in each community or locality. Competition, jealousy, isolation must be replaced by integrated programs. Unfit hospitals and hospitals that have outlived their usefulness should be reformed or closed.

The public should be educated about hospitals but this education must be based on a sound program of public service by the hospitals of each community. Publicity without a definite service program is shallow and often fruitless; based on such a program it becomes vital and productive. Group hospitalization, health insurance and similar matters need to be considered in formulating this service policy.

The whole question of financial support of hospitals needs examination. Like education of the public, however, it can be solved best only if it is preceded by a careful exploration of the service that an institution can render and formulation of a sound program to provide that service.

It is time that governmental authorities — federal, state and local — accepted their proper financial responsibility for the hospital care of the indigent and that hospitals accepted their corresponding duty to provide a high quality of service to the indigent on an economical basis.

Nursing should be a dignified profession based on adequate educational preparation and sound concepts of service to society. Hospitals may vitally assist in realizing this goal.

Hospitals and the medical profession should co-

operate on the basis of a realistic acceptance by each group of its own and the other group's opportunities, duties and limitations.

Most hospitals should effectively participate in the public health work of their communities through public education and through the provision of facilities and the adoption of policies for disease prevention and the promotion of positive health.

The automobile accident problem can and should be solved in a way that will be fair to hospitals, autoists and victims of accidents.

Hospital trustees should be educated and assisted so that they may meet their proper responsibilities fully, intelligently and with social consciousness.

The time has now come for the development by hospitals of distinctive services which will lift them far above the minimum requirements of standardization programs.

The MODERN HOSPITAL pledges itself during the coming years to use its best effort to assist in the solution of these problems. The magazine will not only continue to be a forum wherein the thoughtful members of the profession may discuss these and similar questions from all points of view, but when issues are clarified it will concentrate its energies upon obtaining general acceptance of ideas that may be of proved value to the field.

Spinal Rigidity in Executives and Board Members

THE human spine is a finely articulated collection of disk-like vertebrae so firmly appositioned that it serves as a support for the whole human frame. It makes possible the maintenance of the erect posture. Possibly because of this fact it has become a synonym for firmness of decision, for fortitude in defending the individual's idea of rectitude, for strength of character.

Board members and hospital executives sometimes display rather definite evidences that their spines are far from rigid. They fear the opinions of others. They vacillate because ethical vertebrae are not wholly stable. The board that changes its policies with the weather vane invariably heads a hospital that is gossipy and low in morale and efficiency.

To take a firm stand on a staff matter, to incur the displeasure of a prominent and influential colleague by warning against personal interference with hospital administrative matters, to demand the resignation of an ineffective but popular executive, all require the exercise of spinal rigidity. To temporize, to delay the day of decision, to utter

soft words when stern phrases are required, to seek for the easiest and pleasantest way out, is to evade the duty placed by the community on every hospital worker.

The executive who is inclined to assume the position of recumbency in his dealings with the board and his subordinates is to be pitied. But a hospital board that has no policy or opinion or, having one, fears to enforce it deserves any opprobrium that an aroused community cares to bestow upon it.

Off for Philadelphia

With my pack upon my shoulder
Sure there's no man could be bolder
And I'm off for Philadelphia in the mornin'.

S O RAN a lilting ballad of three decades ago and so will soon sing many members of the hospital guild who plan to attend the thirty-sixth convocation of the American Hospital Association.

Every hospital board should insist that its executive attend the coming convention. After a great crisis has been reached and recession or readjustment begins there is a period of rehabilitation — of surveying the signs of the times for guides for future conduct. Some expedients adopted perforce have proved useful and are worthy of continuance; others were but stop-gaps and should now be discarded. A gathering of hospital executives is the time and place to compare experiences and thus learn the quickest way of repairing the damage done to the institution's finances and prestige.

Penny Wise

JAIL sentences were rightfully dealt out to two individuals who recently sold impure ether to several credulous hospital executives.

The practice of buying supplies and equipment from itinerant, unknown and wholly irresponsible salesmen is worse than penny wise and pound foolish because it may place human life in jeopardy. If the quality and, in the case of chemicals, the purity and safety of the goods could be judged by inspection, all might be well. But, laying aside the obligation which many institutions owe to responsible houses that have carried their accounts when there were no funds to meet them, no executive, regardless of skill and experience, can judge either the purity or the weight of drugs or the durability of rubber goods simply by examining them.

Petty business practices are reprehensible but the purchase of poor or impure food, drugs or chemicals because they appear to the superintendent to be cheap may approach criminal negligence.

Let's Fill Those Empty Beds

By CARL A. ERIKSON

Schmidt, Garden & Erikson, Architects, Chicago

A BATTLE between income and outgo ever rages in the hospital. In the past few years, the outgo has had all the best of it. But the big guns have gradually weakened the outgo by reducing operating costs markedly. That phase of the battle is about over for the outgo now seems to be firmly intrenched behind its pill boxes; it is attacking again through increased commodity costs.

Somebody once said that the best defense is an attack. Perhaps the best defense against increased outgo is increased income. There are several ways of increasing income and for many of our hospitals one of them is through better quarters for patients. Quarters may be better in that they are adjusted to current economic conditions, or that they provide better service to the patient, or that they are more attractive, or for all of these reasons.

Adjustment to current economic conditions is only a highfalutin way of saying adjusting the patient's quarters to his and the hospital's pocket book. But these interests conflict. The reduction in nonoperating income in some of our best known hospitals has been so marked that free and less-than-cost service has been seriously curtailed. Consequently, wards are accumulating dust. Simultaneously many of these hospitals find their expensive private rooms standing empty. In the case of many older hospitals this is because of the competition of newer hospitals with more attractive private rooms.

Making Rooms Attractive

It should ever be remembered that the walls around his room bound the patient's world. And to his visitor, the room housing the patient, the corridors, the elevator and the front entrance are the hospital. Not more than 25 per cent of the hospital floor area is devoted to patients' rooms or wards, yet by that quarter is the hospital known to its users. No matter how magnificent the other three-quarters may be, it does not count.

Merchants demonstrate that everything can be sold at some kind of a price. If a dress does not sell at its original price, it is successively reduced until it does, though that may be a small fraction of its cost. That way lies bankruptcy for the hos-

pital. Auto manufacturers recently demonstrated another method — improving the car without an increase in price. The customer's satisfaction thus attained results in increased business, which justifies the lowered cost. Probably it is along these lines that the remodeling of patients' quarters should be considered.

The first step is an analysis of the possible market. It does not increase income to charge \$3 per day for ward beds if nobody pays it. The wards will stand empty; the hospital saves slightly on its operating expenses and the community suffers. But could not that space be converted into quarters that would be sufficiently attractive so that it would be nearly self-sustaining?

When Ward Beds Are Unoccupied

Let us take the 16-bed ward in a well known hospital. The hospital's income has been so seriously depleted that many of these wards (largely free patients) had perforce to be closed. Roughly speaking, the deficit on each of these wards when occupied was not less than \$8,000 a year. This ward could be converted into ten small private rooms. If these could be kept filled at a flat charge (no extras) of \$4 per day, and if the operating costs averaged for the institution \$5 a patient day, the hospital would just about break even. Breaking even when selling at less than cost — that is an old practice in merchandising and one that deserves wider application in the hospital world.

There are not many places in which private rooms at \$4 per day (no extras) would not go like hot cakes. Where would the patients come from? Some would come from the wards, the two-bed rooms, and some of the private rooms, but far more would come from that tremendous group that will not enter the wards and cannot pay for private rooms as presently priced.

On the other hand, there are doubtless hospitals with too many private rooms; the need may have been overestimated. Possibly community needs would be better served by two-bed wards, an obvious and simple change in those hospitals with rooms large enough to permit it.

The older private rooms in our hospitals are usually a most fertile field for rehabilitation for here—granted a sound structure—the swankiest

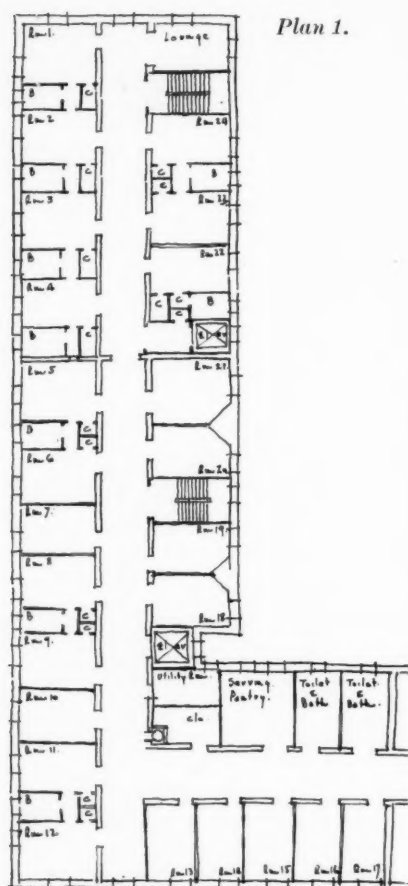
conditions in the more recently constructed hospitals may be produced, often at small cost. Generally, these rooms suffer from poor furniture and decoration.

No matter how carefully cared for, the furniture of twenty years ago is likely to be old-fashioned if not moth-eaten; unfortunately there are only a few things that can be done about it. If the furniture has good lines and is otherwise sound, it may be possible to change the shiny red mahogany into the almost natural color with no varnish. If an upholstered chair is added, if the big mirror is detached from the dresser and a small wall-hung mirror is substituted, if new wall paint, hangings, a new floor covering and attractive lamps are added, the room may then justify private room rates.

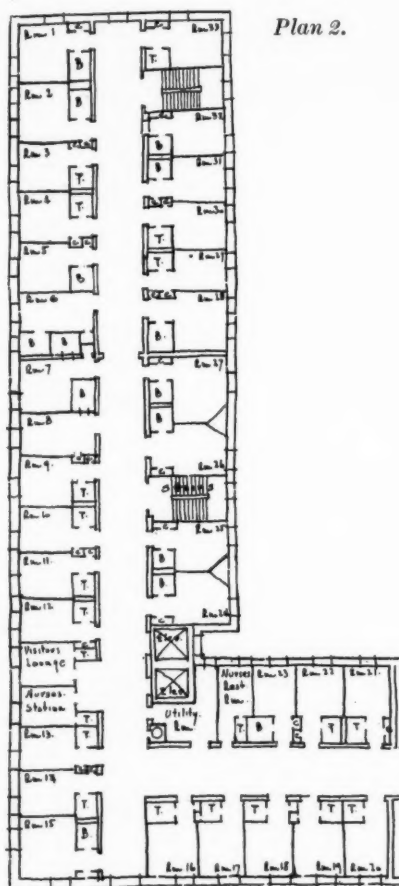
Often hospital rooms are too large and too high—barns, they are. Others have none of the conveniences of today—ample electric convenience outlets, running water, wash basins, private toilets. While there may be some who question the utility of private toilets for each room, no one doubts the demands of our room-and-bath conscious public. If rooms are more easily rented, is not the expense justified? There is another group of large rooms that have connecting baths—a snare and a delusion quite prevalent up to about 1920. Thousands

of such rooms are in use today; they must either be priced low or else stand vacant except when more modern ones (at slightly higher cost) are not available. Or if the hospital has nothing else, the patient grudgingly pays the price.

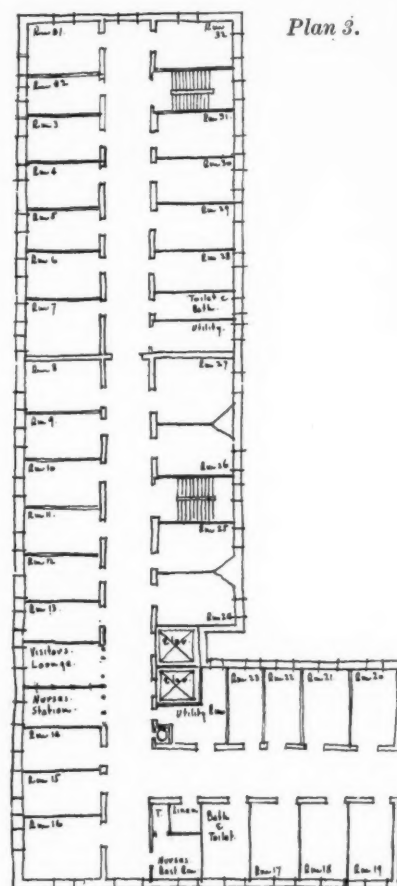
To determine what should be done with such rooms requires a study of each case. To illustrate the possibilities with these old-fashioned private rooms, I have made a study of the private patients' wing in one of the larger hospitals. The wing, which we are to analyze here, was erected in two parts, the first in 1907 and the second in 1912. It represented the best in the prevailing ideas of finish and construction. Fireproof and well built, this hospital of assured standing in the community and with the medical profession has found that the occupancy of its de luxe patients' quarters varies from 30 to 60 per cent. The rooms are large and they are well furnished with the excellent mahogany furniture installed a quarter of a century ago, still in excellent condition. There are no electric convenience outlets and the electric fixtures are of the era. The floor is wood with a few small rugs, the only concession to comfort. Of the twenty-four rooms only one has a private bath, twelve have a bath in common with an adjoining room and the other eleven have not even a wash basin in the room. The two elevators are adequate,



Plan 1.



Plan 2.



Plan 3.

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COMPARATIVE GROSS AND NET INCOME FROM PRIVATE PATIENT
FLOOR UNDER THREE ALTERNATIVE PLANS

Type of Room	Present Plan			Plan 2			Plan 3		
	No. of Rooms	Rate	Potential Income	No. of Rooms	Rate	Potential Income	No. of Rooms	Rate	Potential Income
With private bath.....	1	\$ 9.00	\$ 9.00	15	\$6.00	\$ 90.00	..	.....	.....
With toilet	0	0.00	0.00	18	5.00	90.00	..	.....	.....
With connecting bath.....	12	7.50	90.00	0	.....	0.00	..	.....	.....
Without bath.....	11	6.00	66.00	0	.....	0.00	..	.....	.....
Two-bed rooms.....	..	.....	.....	..	.....	.....	32	\$4.50	\$144.00
Total.....	24	6.89 ¹	165.00	33	5.45 ¹	180.00	32	4.50 ¹	144.00
Estimated extras.....	..	.....	82.00	..	.....	90.00	..	.....	72.00
Potential gross daily income..	..	.....	247.00	..	.....	270.00	..	.....	216.00
Average total charge per bed..	..	10.29	.....	..	8.18	.....	..	6.75	.....
Estimated actual daily income ² ..	..	.....	123.50	..	.....	216.00	..	.....	172.80
Cost per day ³.....	..	.....	84.00	..	.....	158.40	..	.....	128.00
Net difference.....	..	.....	39.50	..	.....	57.60	..	.....	44.80
Amortization and interest— 10 years.....	..	.....	0.00	..	.....	16.45	..	.....	8.22
Daily net income.....	..	.....	39.50	..	.....	41.15	..	.....	36.58

¹ Average total charge per patient.

² Estimated on the basis of a 50 per cent occupancy under the present plan and an 80 per cent occupancy under each of the other plans. This gives an average of 12 patients per day under the present plan, 26.4 patients per day under Plan 2 and 25.6 patients per day under Plan 3.

³ Estimated at \$7 per patient day under present plan, \$6 per patient day under Plan 2 and \$5 per patient day under Plan 3.

but as they are separated the service is slow. The nurses' station is in the end of the corridor considerably off center of the unit. There is no special rest room for nurses or visitors' waiting room. Obviously, there is much grumbling about the prices asked for these rooms, for more attractive quarters are available in other hospitals near by. When the patient has a choice of hospitals—and many staff members have two or more hospital connections—this hospital often loses the patient to a more recently built hospital though its service is admittedly second to none.

Plan 1 shows the present typical floor. A highly centralized food service is in satisfactory operation so the former serving pantry is no longer used as such. In setting up the operating results, I have used lower figures than are actually charged, but I have likewise used lower per capita figures than would probably show with a careful cost accounting system and a 50 per cent occupancy. The net shown in the attached figures is probably greater than actually produced.

Converting Private Rooms Into Small Wards

The hospital could easily convert all these rooms into two and three-bed wards; these if occupied (and that is doubtful) at prevailing prices would increase the hospital deficit. It would require considerable money to provide the additional toilets and utility rooms that would be necessary. The hospital's income does not permit any increase in less-than-cost patients, and its records show that

with a very few private rooms at \$5 a day shows they are almost always full.

The average fixed rate per room with the present arrangement is \$6.89 a day, but the actual cost to the patient because of extra charges is probably 50 per cent more, or \$10.29 a day. If these costs to the patient could be reduced by 20 per cent, if at the same time private toilets and baths could be added for every room and if furniture, equipment and decoration were brought up to the minute, it would broaden the demand considerably.

Adding Baths and Toilets

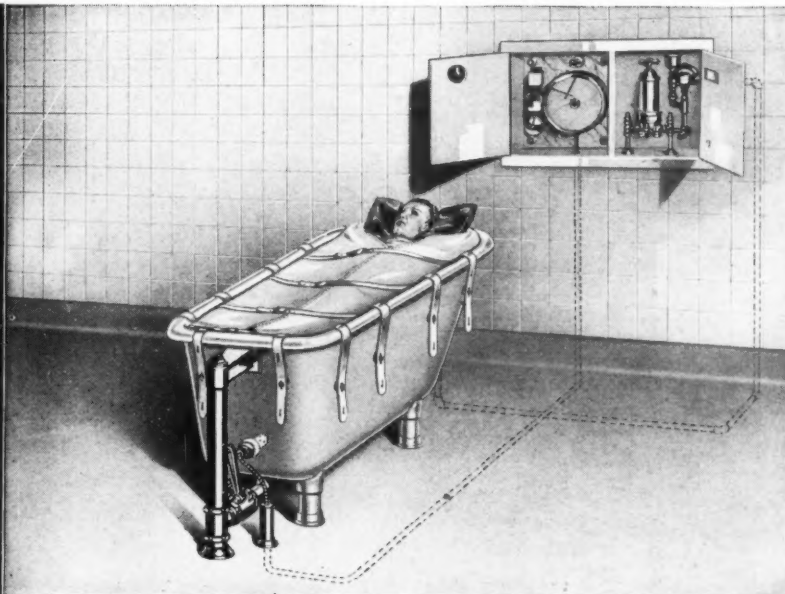
Plan 2 illustrates how this might be done. Instead of 24 rooms with one private bath and six connecting baths, there would be 33 rooms with 15 private baths and 18 private toilets. In determining the rates shown in the tabulation, I have made several assumptions with which you may quarrel, if you wish, but which seem reasonable to me. I have assumed that the \$50,000 investment for changes (probably a high estimate) with 4 per cent interest must be written off in ten years; that is an absurdly short time in which to write off the capital investment. I have also assumed that the income from the floor must not be less than it is now. The occupancy is assumed at 80 per cent. Considering that there is no increase in either general or unit overhead while the occupancy of the floor area is increased 120 per cent, a reduction of the operating costs from \$7 to \$6 per capita seems proper.

if such quarters are priced to break even they are not likely to be occupied.

The hospital's experience with a limited number of rooms with adjacent toilets priced at \$6 and \$7 a day and

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Then, if you must have the latest wrinkle, a further investment of from \$15,000 to \$20,000 will completely air condition these rooms; amortization of that sum would add 25 cents a day to the room rates. Will they sell!

If analysis of past experience had indicated that even these quarters at a 20 per cent reduction in costs to the patient were hardly feasible, then Plan 3 might be considered. In this plan there are no private baths and toilets, but each room has its own wash basin and an additional utility room, and two general toilets and baths are added. Otherwise the furnishings and auxiliaries are identical with those suggested in Plan 2. The cost is figured at only \$25,000; consequently the amortization charge is reduced proportionately. It is assumed that the cost of the care of these patients, not being able to afford the luxuries of private baths or toilets, might be reduced to \$5 per day.

Plan 3 Features Larger Rooms

As the per capita cost of the rooms as they are is estimated at \$7, the \$5 per day per capita may be questioned. It should be observed, however, that except for nursing care, food, laundry, depreciation on furniture and its maintenance, and similar items, there is no change in the operating expenses of the hospital. Yet the average occupancy of one floor in this unit is figured to be increased from 12 to 25.6 beds, an increase of something more than 100 per cent.

An increase of 13.6 beds in a hospital with an average occupancy of more than 200 would not need increased personnel in any department unless that department were badly undermanned for the existing load; in such an event the cost of the additional personnel is not properly chargeable to the increased patients.

The rooms in Plan 3 are larger than in Plan 2 and with modern furniture, conveniences and decoration. It seems fairly reasonable to price these at \$4.50 a day even though they do not have toilet or bath. Yet the investment can be amortized in ten years and about the same return obtained as in the present arrangement. Would these smaller, yet modern and attractive rooms rent at \$4.50 when the barnlike old-fashioned rooms at \$6 go unoccupied!

If the indications are that two-bed rooms would prove popular, Plan 2 can be converted into ten private rooms (too small for two-bed rooms) and 22 two-bed rooms, making a capacity of 54 beds

on this floor. If the cost were assumed at \$5 per day, with an 80 per cent occupancy, the private rooms could be rented at \$5 a day and the two-bed wards at \$3.50 a bed and still amortize the investment in ten years and leave something over operating expenses.

In both Plans 1 and 2, no structural changes are contemplated. The stairways, badly located as they are, are untouched because to change them would necessitate alterations on all floors of this six-story building, adding considerably to the expense. While one elevator is shown in a new location, the cost of that change is not included in the rather liberal estimate of the cost of alterations, inasmuch as it is a general improvement affecting all floors of this building and, therefore, should be pro-rated. Few, if any, changes in the windows are contemplated. Both plans are based on the assumption that only one floor would be remodeled at a time so as to permit the continuous occupancy of the rest of the hospital, and also to permit the operating results to determine whether more than one floor should be remodeled in this manner.

In this case, it seems impossible to provide any additional less-than-cost bed capacity, which automatically ruled out any rearrangement that included ward beds. It is well remembered, too, that Plans 2 and 3 are only sketch studies, and a more careful analysis attendant upon execution would undoubtedly result in many improvements.

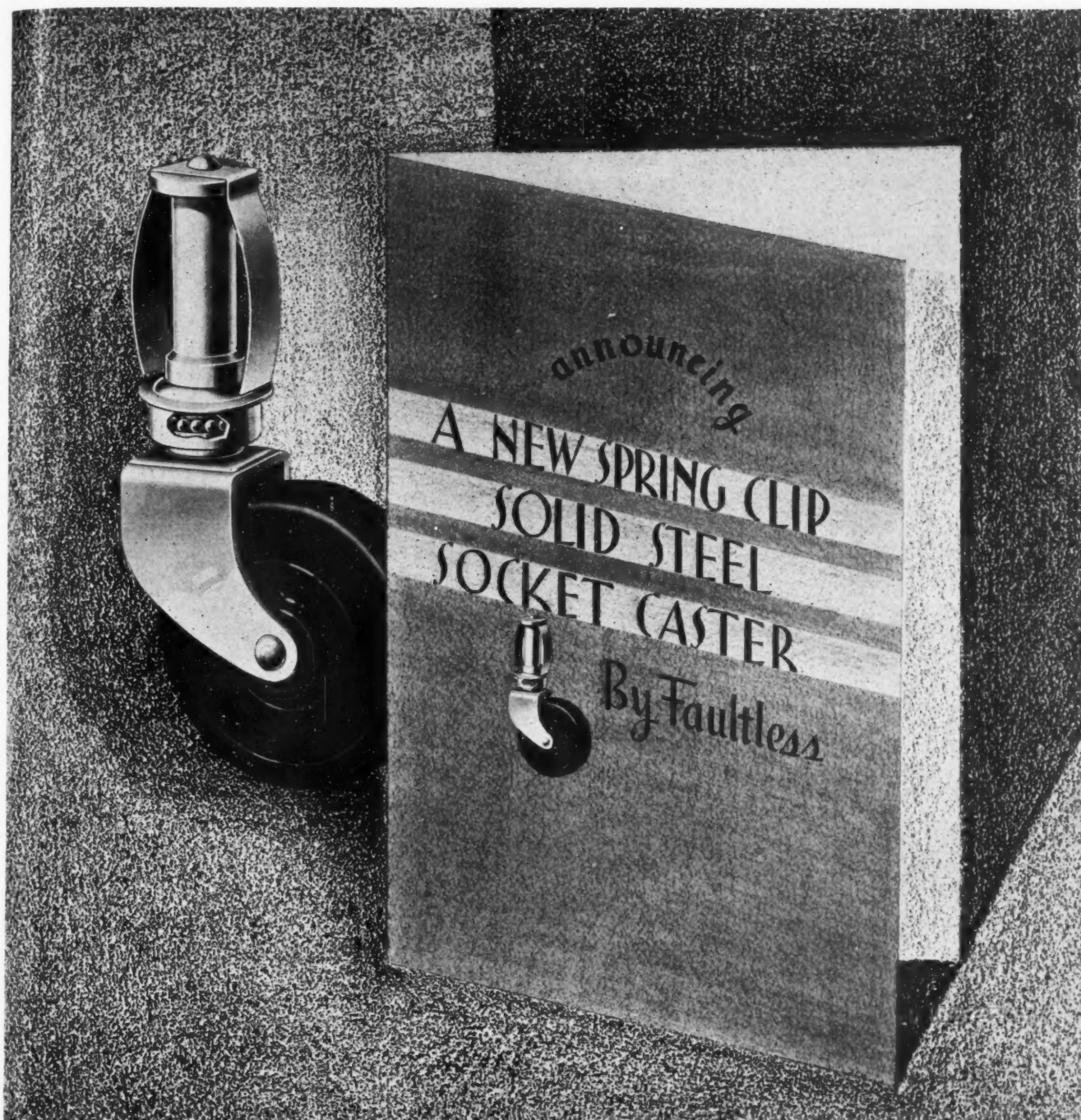
A Rush of Patients for Bargains

This has been a hard-boiled analysis. I have considered it solely as a practical business problem. While I recognize that increased service to the community through lowering rates would be made possible by such an alteration as this, particularly to the white collar class, yet I have managed to keep the tears out of my eyes while thinking about the problem.

The selling of rooms is a merchandising problem with two people to be sold—the doctor and the patient. If a superior accommodation (and I believe that even Plan 3 is superior to the existing building arrangement) can be sold at a reduction of from \$10.29 a day to \$6.75 a day, or 38 per cent, the rush of patients might approximate that at a basement bargain counter. Even though the operating results were not what I have figured them, they might still be justified financially on the same principle as the stores do their "leaders," which they sell at cost or below cost to attract buyers into the store.

It is a very old economic principle that lowering prices increases the potential buyers tremendously—that's why there are only a few thousand Lincolns sold but millions of Fords.

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Ohio State University Develops a New Nursing Curriculum

By RUTH ALICE PERKINS

Director of Nursing Education, Ohio State University

THE Ohio State University has in the past few years offered two courses in nursing education: the basic three-year course and the five-year education-science nursing program. The three-year course was under the direct administration of the college of medicine. The five-year curriculum is offered by the college of medicine in cooperation with the college of education. The degree, Bachelor of Science in Education, is granted by the college of education.

During the last two years the department of nursing education had been looking forward to dropping the three-year curriculum in order to raise the standards of nursing within the university. Overproduction of nurses in the general duty and private duty fields was an important factor in this movement. An analysis of the clinical material available at University Hospital pointed definitely toward smaller classes supplemented with general duty graduate service.

The splendid work being done at the present time at the University of Washington has offered a definite stimulus to other universities to go forward with further research and experimentation in order to determine the place of nursing in state universities. With all of these factors in mind, Ohio State University has officially dropped the three-year nursing curriculum. However, the present group of three-year students will be permitted to complete their course.

Last year the administration of the school was separated to a large extent from the educational program. The superintendent of the hospital, Margaret M. Reilly, R.N., B.S., took over the administration problems and became superintendent of nurses. A director of nursing education was

appointed to take over the responsibility of the educational program.

Development of the five-year program is progressing under the direction of an advisory committee to the director of nursing education. Three members have been appointed from the college of education and three from the college of medicine. Besides carrying forward the work of developing the new curriculum, the committee is available to the director of nursing education whenever and as often as the need for conference arises.

Hospital service is separated from the educational program down to the level of ward practice. Responsibilities are divided depending on the problems that arise. If a problem involves hospital administration it is referred to the superintendent of nurses; if it is basically edu-

cational it is referred to the director of education. Problems involving both administration and education are disposed of in conference or referred to the advisory committee.

In connection with the five-year curriculum, a co-operative program for graduate nurses has been passing through the experimental stage the past year. In return for thirty-six hours a week of general duty nursing service at University Hospital, the graduate registered nurse wishing to complete her

work for a bachelor's degree in education receives board, room, laundry of uniforms, incidental fees to the university (all tuition expenses except matriculation and laboratory fees), and \$15 a month in cash. Nurses from states other than Ohio who accept this cooperative program are not required to pay nonresident tuition fees. These part-time graduate nurses work six

Another step forward in raising the standards of nursing has been taken at Ohio State University. Because of overproduction of general duty and private nurses, the basic three-year course has been discontinued in favor of a five-year course. Graduates of this course will receive the degree of Bachelor of Science in Education

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Sealex is highly suitable for hospital modernization work. It is quickly installed over the old floors without costly preparation. Write for full information about Sealex Linoleum and the permanent, washable Sealex Wall-Covering. When installed by authorized contractors, both materials and workmanship are backed by a Guaranty Bond.

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hours a day for six days a week. One whole day off duty is arranged weekly. Graduate nurses from accredited hospitals meeting the entrance requirements of the college of education enter the education-science nursing program with junior class standing. It takes approximately two and one-half years for nurses attending college on this part-time schedule to complete the work for a Bachelor of Science degree in Education.

This plan appeals to the young unemployed graduate nurse since it offers her a chance to complete her work for a degree on a cooperative basis at a time when positions are at a premium.

Nursing Done in Six-Hour Shifts

Four shifts of six hours each make up the cooperative schedule: 6 a.m. to 12 noon, 12 noon to 6 p.m., 6 p.m. to 12 midnight, and 12 midnight to 6 a.m. Student nurses work from 7 a.m. to 7 p.m. with three hours off duty on the day shift. Night duty is assigned only on special services, obstetrics, for example, in order to obtain the required number of cases. Additional night duty may be assigned to student nurses during the summer quarter when classes are not in session.

The six-hour graduates are permitted to sign up for preferred shifts when they present their class schedules to be approved for the following quarter. The number of six-hour nurses required on each six-hour shift is estimated in advance and placed on the shift sheet. For example, if a six-hour nurse comes into the office with her schedule made out for morning classes she may sign up for any one of the three remaining shifts. If fifteen six-hour graduates are needed on the 6 p.m. to 12 midnight shift, that column is closed after the fifteenth nurse has registered for that shift. In other words, it is a "first come, first served" proposition. This permits the graduate to make out her class schedule and then sign up for the shift she needs. If she has classes both in the morning and in the afternoon, as frequently happens when she is working off her laboratory subjects, she may work either evening or night shift. Shifts change at registration time but remain fairly constant during the quarter.

Nurses on evening and night shifts are relieved by graduate nurses who circulate from one ward to another. Since there are two nurses on a ward there is always one regular nurse on duty. Coming on duty at 6 a.m. seems to offer no problem either with the students or the administration. The nurses report to their assigned services at 6 a.m. and are relieved for breakfast by the student nurses coming on at 7 a.m. It necessitates an extra report but it is felt that this is offset

by the fact that nurses give better service on the six-hour plan than on the eight-hour plan.

Undergraduate nurses given the split shift are enabled to gain their bedside experience during the two heavy working peaks of the day and, from the standpoint of the administration of the hospital service to the patients, the heavy working periods are provided for. This cooperative service also stabilizes the wards while the students are at class.

Both students and graduates are to be housed in one of the regular college dormitories. They are eligible for all social activities on the campus and are under the supervision of the dean of women and the student government association.

A careful and detailed study of the curriculum is being made under the direction of W. W. Charters of the bureau of educational research. The new curriculum will be developed with both the undergraduate and graduate group in mind. An activity study of nursing has been under way for the last two years. Parallel to this study, an analysis of the nursing needs in the basic sciences is going forward. A detailed study of the clinical material available for teaching purposes has offered a third avenue of approach in the curriculum study.

On the basis of this research, further experimentation will be done in an effort to determine on a scientific basis the place of nursing education in the state university.

Nurses' Home Does Not Need a Beauty Parlor

There is a tendency in the construction of nurses' homes to practice extravagance to a degree that is a disadvantage to young nurses. There must be in many instances a strong contrast between the homely but comfortable surroundings from which these young women come and the atmosphere of luxury in which they live during their training school days. A still greater contrast is frequently observed between the living accommodations that are provided for student nurses and their mode of living following the completion of their training.

It is perfectly evident that young women studying nursing should be supplied with comfortable rooms, study halls and recreation spaces during their training course, but to supply luxuries is wasteful. In some institutions, not only swimming pools and gymnasiums are provided in the home for nurses, but also beauty shops, shoe shining parlors and personal laundry facilities. The average institution cannot afford such facilities. There are many ways that practical savings can be made in the construction of a nurses' home without depriving the students of essential comforts. Eliminating the beauty parlor is one way of saving money. It is much more sensible to improve recreational and classroom facilities with funds that may be available for luxuries. Nurses who can afford to patronize a beauty parlor can be accommodated at commercial establishments.



"What was the Appearance before Treatment?"

THIS may be the question of an interested student or colleague. It may be addressed to a witness by an antagonistic attorney. In any instance the photograph gives a clear, complete reply. Where words alone can not describe a condition satisfactorily . . . when time has dimmed the memory of details, photographs provide exact, readily understandable information.

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A Device for Producing High Grade Distilled Water

By MARIAN E. STARK, Ph.D.

Department of Clinical Chemistry, Wisconsin General Hospital, Madison

AMATTER of primary importance in hospital operation is a supply of distilled water adequate in both volume and quality to meet the most exacting needs, first, of intravenous therapy and, next, of the chemistry laboratory when the latter is included in the hospital organization. In the smaller institution both these needs can be satisfied by any good standard type of still provided its management is in careful hands so that only freshly distilled water is used for the making of intravenous solutions and provided that these solutions are always promptly sterilized.^{1, 2}

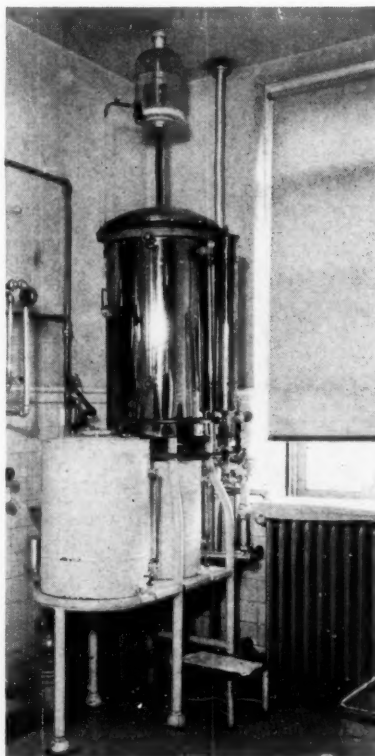
As the size and scope of the institution increase, the water needs mount in volume and also in the range of exacting needs that must be fulfilled. At the same time, responsibility for control is so greatly scattered that continuous safety can be assured only with some sort of distilling equipment which is practically automatic in operation and in which all the safeguards necessary for assuring the highest possible quality of the water are built into the design and not in any way dependent on the personal idiosyncrasies of those who operate it. These considerations and the desirability of further standardization of hospital practice along these lines have been well set forth in previous articles in *The Modern Hospital* by McLean³ and by Perkins.⁴ Excellent reviews of the work of others and discussions of the much disputed

question of causes for reactions after intravenous therapy are given by both of these authors.

It has been conclusively demonstrated by Seibert, in a classical piece of work¹, which can bear citing again because it is undoubtedly still too little known, that the material predominantly responsible for febrile reactions following intravenous injections is a product of contamination of the water by certain strains of bacteria — not the bacteria themselves but a substance, probably a toxin, which they produce. This develops as the contaminated water is allowed to stand and can therefore be avoided by means of prompt sterilization.

After the pyrogenic material is once present, however, autoclaving is of no avail, for the material is highly resistant to heat. Small amounts of the material may suffice to produce even severe reactions and the contamination is easy. This work has been completely confirmed by Rademaker.⁵

Either the bacteria themselves or their toxic products can be carried over in distillation by entrainment with the steam, and although an efficient system of baffles combats this^{1, 4, 5} it is doubtful if any such scheme simple enough to be practical could be relied upon alone for safety under all circumstances. For instance, its protection could certainly break down if the distillation were sufficiently speeded up. The classical way of dealing with

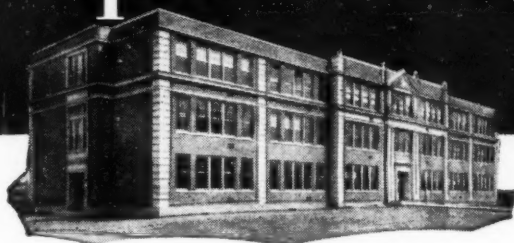


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MAINTENANCE, OPERATION AND EQUIPMENT

this difficulty has been to attenuate it by multiple distillations, which amounts in effect, of course, to an admission that the process itself is not perfect. Thus the large bulk of opinion that triple distillation is the least that should be relied upon in routine practice.³

A still has been developed by Prof. Emil Truog of the department of soils at the University of Wisconsin that combines complete protection against access of even traces of reaction producing material into the distillate, with the requisite simplicity and automaticity of operation demanded by a large group of hospital and laboratory services. The design departs sufficiently from the standard types of water still to merit description in some detail.

Steam from a central heating station, instead of being used to heat raw water, is after a very thorough conditioning and purification condensed directly as distilled water. Three processes in the treatment combine to provide in a single operation a distillate of unusually high quality to meet the most exacting demands of either intravenous or chemical uses. These are (1) passage of the steam through an acidified water-bath; (2) baffling to minimize entrainment, and finally (3) subjection to a large column of high temperature, activated charcoal to remove remaining impurities.

Steam from a central station is usually contami-

nated with grease, iron oxide and various solids, all of which are carried along because of their fineness of division (colloidal state). They are, of course, picked up by the steam as it passes through the conducting pipes and various mechanisms in going from the central plant to the place of use. This general class of impurities is unsafe from the standpoint of delicate chemical work. Of principal concern in the matter of use for intravenous purposes is the further inclusion of materials produced from organic matter on heating, among which may easily be the pyrogenic substances shown by Seibert's work to be heat resistant.

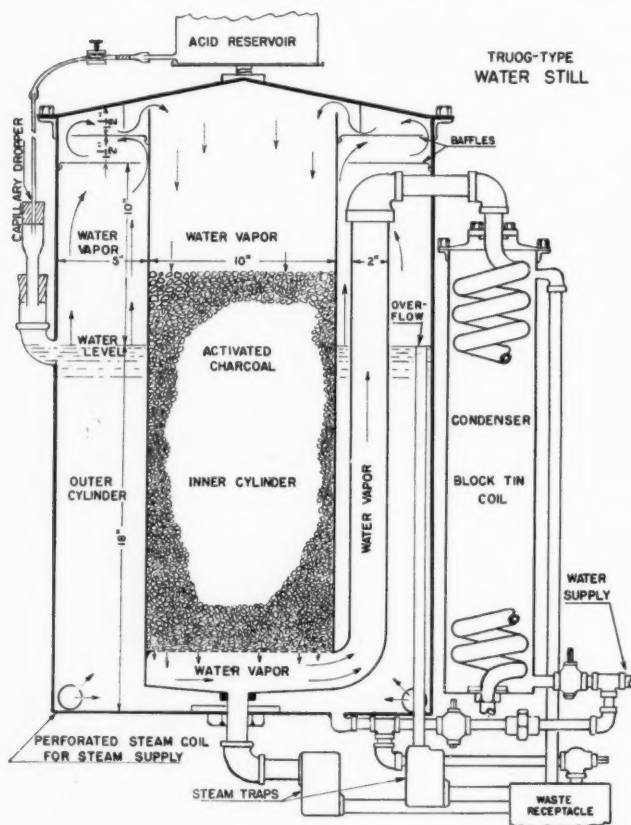
How Impurities Are Kept Out

The Truog-type still combines protection against these different types of impurities by the following simple scheme:

As illustrated in the diagram, steam from a low pressure line is introduced through perforated coils into a large outer cylinder (boiling chamber) and the heat of the steam keeps the water in this chamber at a boiling temperature. Steam rises at the water level and passes as shown by the arrows around the baffles near the top and then down through a central cylinder, which is filled with granular, activated charcoal. The vapor emerges from the charcoal through a perforated plate forming a false bottom in the cylinder, and then passes, as shown, up through the large pipe and finally to the condenser.

The first steps of purification are in the passage of the steam through the water-jacket. Here the velocity of the steam, and as a consequence, its capacity for carrying entrained material become greatly reduced. This makes it possible for the water in the outer cylinder to function as an effective trap for the finely divided solids carried by the steam. In contact with the boiling water these colloidal solids flocculate, become concentrated at the surface, and continually pass off with the water that wastes at the overflow. This continuous overflowing takes place because of loss of heat from the surface of the outer chamber, which results in slight condensation of steam in the interior to augment the original volume of water.

To provide for a positive and effective means of removing ammonia, the water in the outer cylinder is kept slightly acid with a solution of either weak sulphuric acid or acid sulphate, provided by a slow drip through a capillary tube from a reservoir supported above the tank. A three-gallon bottle, delivering at the rate of something like one drop every two minutes, suffices between refillings for several



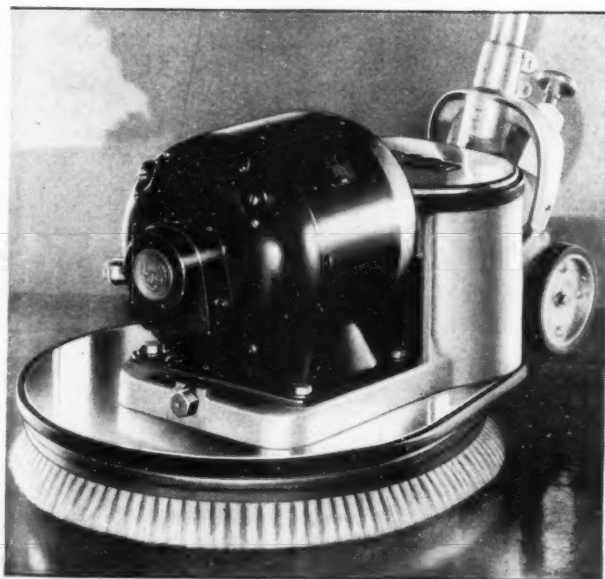
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MAINTENANCE, OPERATION AND EQUIPMENT

months. The soluble but nonvolatile ammonium sulphate passes off with the waste water at the overflow. (No harm from the standpoint of intravenous use would be done if the acid supply should fail, since the small amounts of ammonia carried over without it or the increased pH thus brought about are not of themselves harmful.^{4,5} The acidification is desirable, however, for producing water of the high degree of purity required for many chemical purposes. The pH of the water as taken direct from the still is found to be close to 5.7 after the water has been brought to complete equilibrium with outdoor air, as Truog suggests for standardizing the test.⁶ It is to be noted that pure water in contact with the atmosphere should have a pH of 5.6 to 5.8, and not 7.0.

The function of the baffles has been sufficiently described. Though the presence of the charcoal would make these actually dispensable, their inclusion is simple and does serve, by removing the bulk of entrained solids and semisolids from the steam, to prolong the effective life of a given charge of charcoal.

The charcoal removes the last traces of impurities. Surrounded by the boiling water in the outer cylinder, the charcoal is heated to the point where it does not become wet and covered with a water film, but remains perfectly dry. This and the size of the chamber permit a single charge to remain entirely effective for at least a year or more of continuous operation, depending somewhat upon the quality of the steam and the rate of distillation. In this dry condition the charcoal is a most excellent adsorbent of grease, and any remaining entrained materials are of course also caught by the filter, which acts both as a perfect baffle and adsorbent for these last traces of impurities.

Scaling and Liming

The material of the still throughout is of course pure block tin, or brass, block tin lined, wherever there is contact with the distilled water.

Scaling does not develop in the body of the still itself because after the original starting charge of raw water only ordinary pressure steam has access to the interior, and even the carbonates contained in the original water are carried off by the deconcentrator action of the overflow. Liming will, however, take place gradually on the outside of the condenser coils wherever hard water is used for the cooling. This is the case in the Madison district, but the difficulty from this source has been minimized by bringing the steam into the condenser with a section of block tin piping that is

larger than the rest of the coil for a short distance at the top (not shown in the diagram). Thus the steam begins to condense over a relatively large surface at the point where liming will first take place, as the result of the warming and slowing of the cooling water, and so the deposit is slowed up and distributed over a larger area. This enlarged portion at the place where the positive pressure of the steam is changed to the negative pressure of the dripping condensate acts also as a "vacuum chamber" of increased capacity that effectively prevents the building up of pressure in the interior of the still, thus removing resistance to the drip of acid and any danger of boiling over at the entrance of the capillary tube when the operating pressure of the steam is increased. The actual pressure in the space above the water in the boiling chamber under these conditions is found to be negligible.

These provisions materially retard but cannot altogether prevent eventual depositing of lime salts on the outside of the coils from hard water used for cooling. Therefore, the condenser is provided with a removable cap so that the appearance of the coils can be periodically examined and when necessary the accumulation on the pipes may easily be removed by cleaning with acetic acid.

Still Is Run Continuously

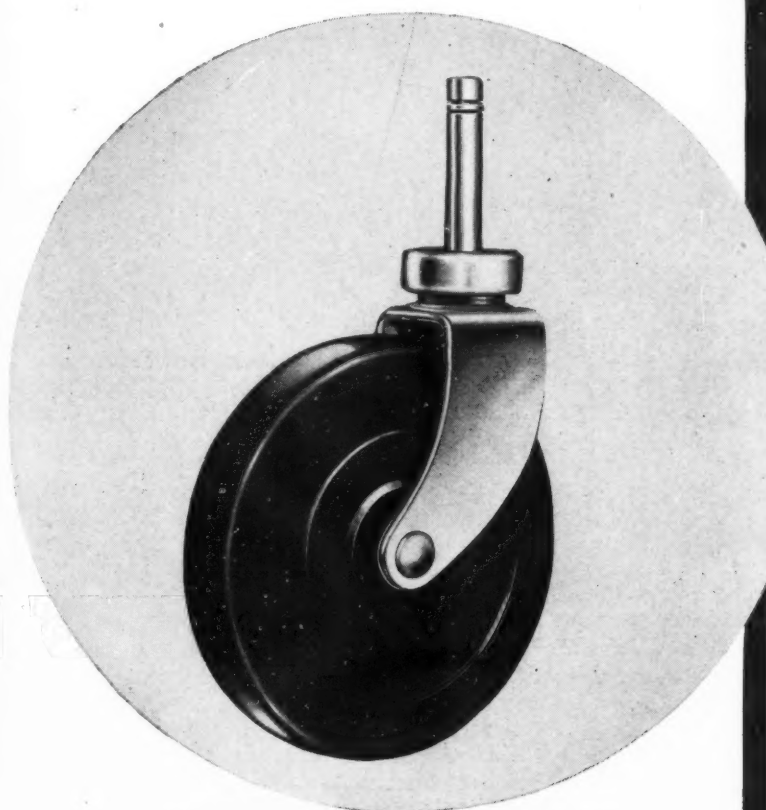
The capacity of a still having the dimensions given in the diagram is at least 3 gallons an hour. Its general size can be deduced from the scale markings on the drawing. The one in the Wisconsin General Hospital is somewhat larger and is conveniently kept operating around 4 or 5 gallons an hour, though in times of unusual demand much greater speeds may be attained. Regulation consists simply in adjusting the two valves that control the inlet of steam and of cooling water. With adequate storage capacity changes in adjustment are almost never necessary.

Storage tanks are provided, in the case of the Wisconsin General Hospital still, of 15 and 25 gallons capacity, so that a generous supply of water may be almost constantly on hand. The larger tank, from which all water intended for the making of intravenous solutions is taken, is provided with steam coils for periodic sterilization. This is merely a factor of added assurance, since, after the interior of the still is once sterilized by live steam — running the still for a short time without cooling water — the distillate remains sterile, as bacteriologic tests have shown. There is, indeed, no opportunity for contamination, provided an effective

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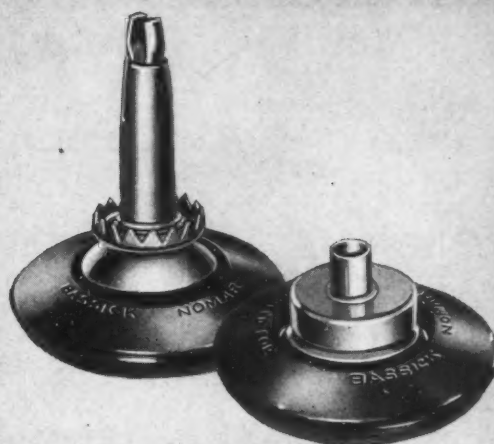
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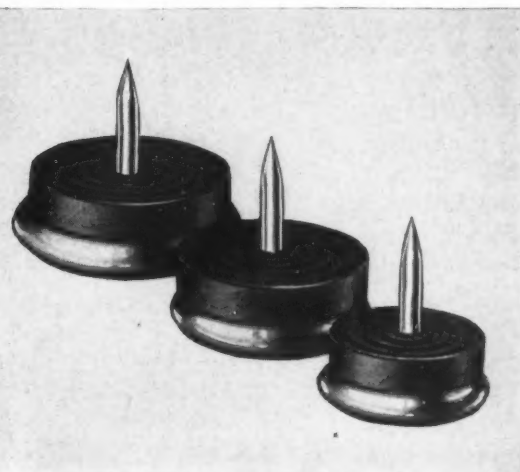
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Round or square types of "Atlasite" or rubber for desk and table legs or for use as caster cups.

MAINTENANCE, OPERATION AND EQUIPMENT

seal is maintained on the storage tanks. All solutions for intravenous use are resterilized, however, since contamination is always possible as soon as the water leaves the tanks.

To make the storage equipment as well as the distilling process entirely automatic, the two tanks are arranged so that when the larger one is full it overflows into the smaller one, and the latter has an overflow (which is protected by a trap) into the sewer.

It is best to run the still continuously at a rate that is calculated on maximum needs, for the cost of permitting some of the water to waste is small compared to the inconveniences and delays of an insufficient supply and of constant supervision of operation. In any case, the expense of operating a still of this kind is comparatively low because it purifies and then condenses directly the ordinary steam produced at a low cost at a central station, instead of using this to heat raw water and produce more steam.

A still of the type here described has been in continuous operation for more than five years in the department of soils at the University of Wisconsin. Several others, including that at the Wis-

consin General Hospital, have been used for shorter periods of time with equal satisfaction. Chemical and bacteriologic tests from time to time, as well as actual experience in the use of the product for hospital purposes, have demonstrated that the water consistently meets the most exacting requirements for intravenous use. From a chemical standpoint the water is preferable to that which can be expected from double or triple distillation by ordinary methods, since ammonia and even small amounts of spray, foam, grease and entrained organic or inorganic material are held back by the triple protection so they cannot contaminate the distillate. Standard electrometric tests indeed have shown that the water is sufficiently pure for most conductivity work.*

*The author wishes to acknowledge the kind assistance of Professor Truog in the detailed description of the mechanics of the still.

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Rubber Electric Heating Pads Prove Their Effectiveness

By EDNA M. CREE

Supervisor and Instructor in Surgical Nursing, Strong Memorial Hospital, Rochester, N. Y.

Because it is difficult to maintain a constant temperature sufficient to be of therapeutic value and yet eliminate the danger of burns, the development of a satisfactory method of applying heat to the body has long been a problem in the hospital and home.

The most common device for applying heat is the hot water bottle. The accepted temperature for filling is 120° F. The temperature of the water falls to 107.2° F. during the first hour, and at the end of the second hour, to 101.8° F., only 3.2° F. above body temperature. It is, therefore, necessary to assume that the hot water bottle must be filled promptly every hour to be of any value, and that in itself is a time consuming procedure.

Various commercial companies have attempted to solve this problem by producing electric heating pads. The original type with heating coils and flannel cover was limited entirely to dry heat. A moistureproof electric pad for the application of both dry and moist heat is now on the market at a price that makes it available for practical use. Two heating units are embedded in solid rubber, thus eliminating the danger of a short circuit from moisture.

These rubber pads have been in use at Strong Memorial

Hospital for two years. Tests made during that time reveal that the thermostatic control maintains an average temperature of 109.4° F. with a maximum of 125.2° F. These readings were taken by placing the thermometer in direct contact with the heating pad.

Because line voltage may fluctuate and because the heat conductivity of the contacting material causes a variation in temperature, additional temperature studies were made. The pad was placed on a patient over an abdominal binder, and skin temperatures were taken underneath the heating pad and binder. The minimum temperature was found to be 102.2° F. and the maximum was 106.1° F. These findings prove that the heat can be further controlled by inserting several thicknesses of flannel between the pad and the patient, thus reducing the danger of burns to a minimum. During the two years there has been only one burn that might be attributed to the heating pad.

The rubber pads are adaptable for applying heat over moist compresses. They can be used when it is impossible to apply a heavy hot water bottle — for example, over compound fractures in traction. It is the opinion of the surgical staff that the use of the heating pad method for the treatment of infections, especially cellulitis, lymphangitis and alveolar abscesses, has resulted in shorter periods of hospitalization.

After two years of experience, we endorse rubber electric heating pads for the application of either dry or moist constant heat on the grounds of simplicity of operation, minimum danger from burns, moderate cost, adaptability to the majority of needs, and effectiveness in securing the desired result.

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MAINTENANCE, OPERATION AND EQUIPMENT

Ethylene-Oxygen Anesthesia Proves Satisfactory and Inexpensive

By H. LIVINGSTONE, M.D.

Chief Anesthetist, University of Chicago Clinics

FREQUENT inquiries in regard to our experience with ethylene-oxygen anesthesia and questions pertaining to the cost of gas anesthetics have prompted the following report:

Since the University of Chicago Clinics were opened in October, 1927, ethylene-oxygen alone has been employed as the anesthetic agent in 4,973 cases. Ethylene-oxygen with the addition of a small quantity of ether through the gas machine has been employed 1,109 times, while it has been combined with open drop ether on 226 occasions. Local has been combined with ethylene-oxygen in 225 cases. Ethylene-oxygen has been combined with other anesthetic agents, as tribrom-ethanol and spinal, on 57 occasions.

Report Based on 6,590 Cases

This means that altogether ethylene-oxygen has been used in 6,590 recorded cases. In addition, many unrecorded ethylene-oxygen inductions have been employed when ether was the primary anesthetic agent. It is our practice to give all adults or older children an ethylene-oxygen or nitrous oxide-oxygen induction when ether is the main anesthetic agent to be employed. This is done in order to minimize or eliminate an excitement period and give the patient a quiet, rapid induction, thus making his surgical experience less unpleasant and minimizing his dread in case he needs later surgery.

Our results with ethylene-oxygen have proved it to be a most valuable agent. We have had no ethylene deaths, fires or explosions. We employ a grounding system¹ to minimize the chance of explosion. We attempt to keep air humidity at a high level, and in addition have installed mercury switches on our electrical outlets. We do not employ ethylene-oxygen or nitrous oxide-oxygen-ether mixtures when motors, x-ray machines, cautery or other sparking devices are to be used. The too frequent nitrous oxide-oxygen-ether explosions^{2,3} should emphasize the importance of taking the same precautions with this anesthetic agent as with

ethylene-oxygen. We also use precautions to prevent ignition of ether, and in 3,493 ether anesthetics we have not experienced a fire or an explosion.

The high value of ethylene-oxygen anesthesia is emphasized in cases that demand more oxygenation and more relaxation than nitrous oxide-oxygen affords, and on which the use of ether would be definitely harmful, that is, cases with diabetes, nephritis, pulmonary tuberculosis and upper respiratory infections.

With proper care, gas anesthetics may be administered at no greater expense than ether anesthetics. Two years ago we purchased new, modern gas machines. New machines are more efficient and also more economical as regards gas consumption. The device we employ has the added feature of an automatic recorder, which gives added information in regard to the response of the patient to the anesthetic, and is a valuable asset to the chart of the patient, both for immediate study and research purposes, as well as from a medicolegal standpoint.

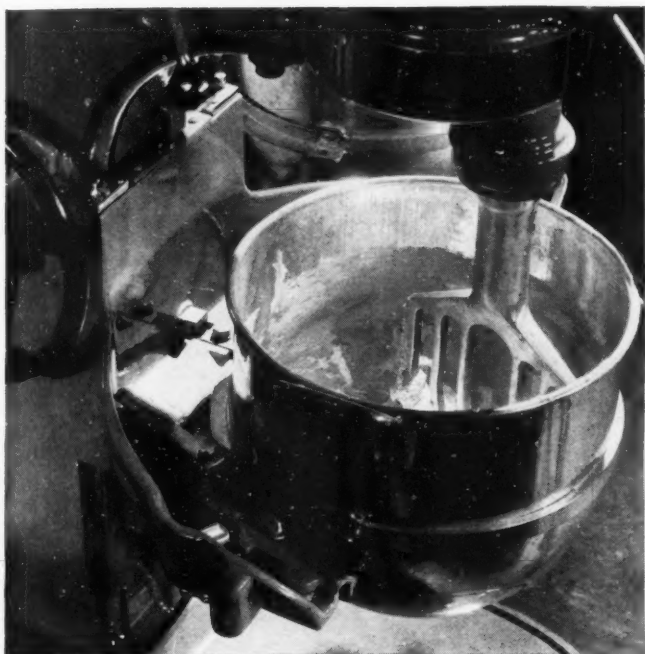
Commercial Oxygen Is Used

Our anesthesia gases—ethylene, nitrous oxide, oxygen and carbon dioxide—are piped to the four main operating rooms from a gas room situated not far distant. With the use of a central gas system large cylinders of gas may be employed. The larger the cylinder used, the less expensive are the contents. In three years' experience with commercial oxygen for anesthesia purposes, we have found it to be most satisfactory. The use of commercial oxygen makes a decided decrease in the cost of our gas mixtures. We also employ commercial carbon dioxide and it has proved to be satisfactory.

The use of a pipeline for the gases eliminates bulky tanks and equipment in the operating room, thus leaving more space for surgeons, nurses and surgical supplies and minimizing the chance of contamination.

At the direction of the anesthetist, a nurse turns

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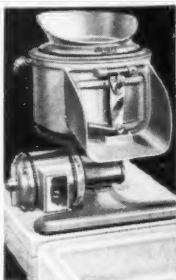
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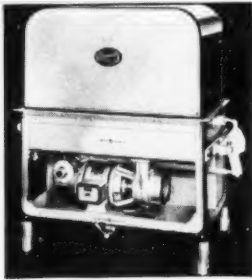
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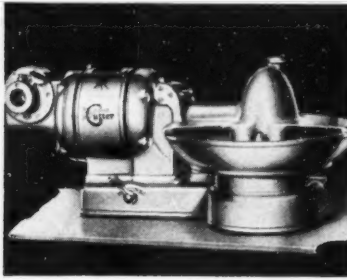
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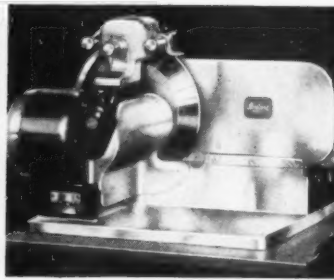
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MAINTENANCE, OPERATION AND EQUIPMENT

off the anesthesia gas at the operating room wall outlet just before the close of each anesthesia. This procedure results in the patient's consuming the gas in the tubing running to the machine, as well as that in the machine, thus eliminating waste at this point. One anesthetist is responsible for turning off all cylinders in the gas room at the close of the day's work. This prevents overnight leakage from the cylinders and also lessens the hazard in the event of a fire in the building. The ethylene is passed from the cylinder through a meter before it enters the gas line, and by careful checks on the meter at the time the gas is turned on each morning any slight leakage in the pipeline can be detected and corrected. Daily gas consumption is also calculated from meter readings that are taken in the gas room.

Rebreathing is practiced on nearly all cases receiving gas anesthesia. Occasionally, in an effort to maintain a satisfactory anesthesia without the addition of ether, it is necessary to minimize the amount of rebreathing. It is not used on cases of pulmonary tuberculosis, where it is necessary not to hyperventilate. The majority of cases are

rebreathed to some extent, thus decreasing the amount of fresh gases necessary. Occasionally soda lime absorption technique is used, but as so many of our patients are given ethylene-oxygen alone without the addition of ether, it is not widely employed. Our surgeons and anesthetists find that a much more even and satisfactory anesthesia results in many cases with partial instead of complete rebreathing, when ethylene-oxygen alone is employed.

With the procedure described we find the average cost of ethylene-oxygen anesthesia is thirty-four cents an hour. Our nitrous oxide-oxygen anesthetics cost approximately the same. This makes either ethylene-oxygen or nitrous oxide-oxygen anesthesia as inexpensive as the average ether anesthesia and much less expensive than tribrom-ethanol or spinal.*

*Thanks are extended to Dr. M. E. Davies for her assistance in obtaining statistics.

References

- ¹Livingstone, H., An Attempt to Lessen Anesthetic Hazards, *Anesthesia and Analgesia*, p. 269, Nov.-Dec., 1930.
- ²Luckhardt, A. B., The Potential Dangers Attendant on Ethylene-Oxygen Anesthesia, *J. A. M. A.*, Vol. 82, p. 1603, 1924.
- ³Herb, I. C., The Present Status of Ethylene, *J. A. M. A.*, Vol. 101, p. 1716, 1933.

Cloth vs. Disposable Diapers

A study of the comparative cost of cloth and disposable diapers has been made at the University of Chicago Clinics where two children's units use a daily average of about 200 large and 50 small diapers.

The large diapers cost \$35 and the small ones cost \$6.42, a total of \$41.42 for the 250 diapers. Since the estimated life of a diaper is 200 washings or 200 days of use, the cost per day for the 250 diapers is \$2.14, and the present cost per cloth diaper is \$0.00856.

Disposable diapers, which would cost \$6.25 per 500, can be used only once. Daily cost of 250 disposable diapers would be \$3.125 and the cost per disposable diaper would be \$0.0125.

Monthly cost for disposable diapers, then, would be \$81.25 as compared with \$55.64, the total monthly cost of the cloth diapers in use at present. This leaves a difference of \$25.61 in favor of the cloth diapers.

Low Washing Costs May Bring High Replacement Costs

Two of the most important laundry costs—steam (hot water) and fabric replacements—are rarely charged to the laundry. The former is charged to the engineering department and the latter to the housekeeping department.

Since hot water costs nearly three times as much as washing materials, some thought toward the conservation of this expensive item is good economy. Free rinsing soap and

other washing materials, automatic water valves, tight valves and connections contribute tremendously to this end. Soaps vary greatly in rinsing quality but they are seldom selected with this in mind. Leaking water, steam and discharge valves should have prompt attention. Small leaks run into a surprisingly large number of dollars.

Too frequently materials and methods are selected with a view to low washing costs only and little thought is given to the effect on the fabrics. Frequently, too, pressure is brought to bear on the laundry superintendent to cut washing costs below his best judgment. Minimum washing costs and minimum fabric depreciation do not go together. The hospital superintendent is not running a commercial laundry. He is washing his own fabrics and replacement is his.

Durable New Finish for Floors and Furniture

A varnishlike material that has just been put on the market has new and interesting possibilities for hospitals. The manufacturers claim that it is really liquid bakelite and that a coat of this material gives the same protection as a sheet of bakelite. Certainly the superficial tests indicate the desirability of pursuing this subject further.

For test purposes a floor finished with this new material was sloshed with alcohol and then the alcohol was ignited. The finish was not damaged. Whether this new material will adhere satisfactorily to all surfaces, whether it will become too brittle for service or whether time will dull its brilliance has not yet been fully checked.



Style and character are in these Marvin-Neitzel capes. Professional every inch of the way, too. Down underneath all the smartness are protection, long wear and all the other characteristics you would want your capes to have.

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Dietetics and Institutional Food Service

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

A Dietitian in Africa and the Near East

By LENNA F. COOPER

Chief, Department of Nutrition, Montefiore Hospital, New York City

WE LEFT New York on the coldest day of the year with the thermometer registering fourteen and one-half degrees below zero. Five days later we were in Madeira, a land of sunshine and flowers, embroidery, wicker ware and wine. The quaint little town of Funchal, where the chief means of transportation is the ox drawn sled, takes one back hundreds of years. But that did not compare with the next port which was only a day's sail away.

Landing at Casablanca in Morocco, North Africa, we began to see life as it was lived hundreds and probably thousands of years ago. Casablanca, however, is chiefly a French city, the commercial center of the country which, since 1912, has been governed by the French. A sixty-five-mile drive by auto through the country revealed the primitive methods of living — the dark, low tents of the Bedouins, huts covered with rush, or perhaps groups of low-roofed huts surrounded by stockades of cactus. The chief motive power was the camel, although we often saw a donkey or a cow hitched to a primitive plow made from a branched limb of a tree to which the plowshare was attached. The storks, which had come a few weeks before, added to the picturesqueness of the scene. Here and there the white-domed tomb of some native saint arose to give contrast to the black camel's hair tents of the natives. Near these tents was a protected corner where the cooking was done with the simplest of utensils.

Fine Architecture in Rabat

The chief means of transportation was the donkey. Not only did he carry his master but the master's burden as well. No one ever seems to hurry, although many of the natives have learned to ride bicycles. This is possible because of the excellent roads and highways that the French have built.

Arriving in Rabat, we discovered two distinct cities — the native and the French. Rabat is the

Menus have not changed much in 2,000 years, says Miss Cooper, who describes in this issue her visits to the food shops of Morocco, Algeria, Tunisia, Tripoli and Egypt. In next month's installment she will tell more of the dietary customs observed in Egypt, Jerusalem, Syria and Pompeii

capital and is, therefore, the residence of both the French governor and the sultan of Morocco. Both palaces are excellent examples of native art and architecture. The sultan's palace, with its harem, is guarded by black soldiers from the Sudan. The artistically barred windows of the palace and of the homes throughout the country proclaim the status of the women.

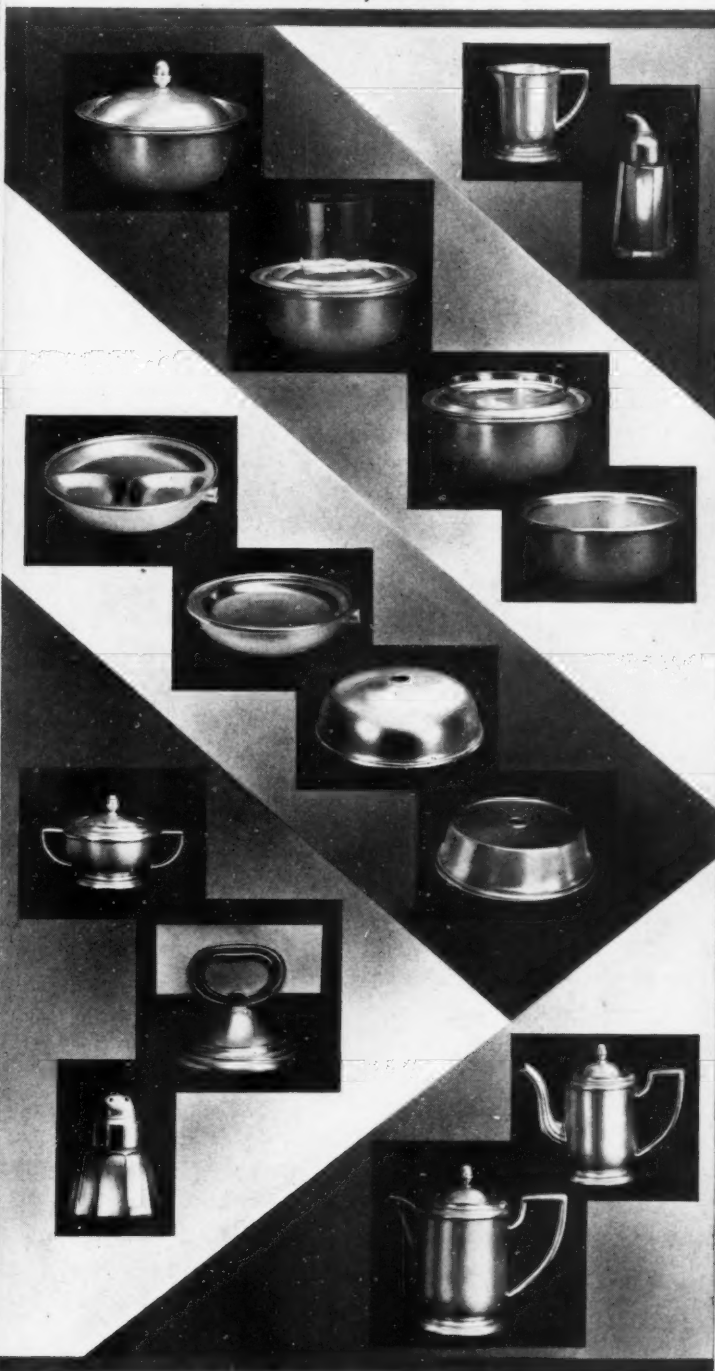
It will be remembered that the native population are descendants of the Moors who conquered Spain and built the beautiful Alhambra and other impressive buildings at Granada and Seville. The French have wisely fashioned the city after the best of Moroccan architecture and art. The Hôpital Marie-Feuillet is an example. Color is added to the white or cream colored buildings, usually in the background of a pillared porch or about the eaves or the window sills. Soft tints of rose, yellow, blue or the softer shades of oriental reds produce pleasing contrasts to the light colored walls. The architecture also makes effective use of various types of arches and groups of pillars. Mosaics and tiles are used in the interiors.

The native city, with its narrow streets, its numerous bazaars and its licensed fountains, is inter-

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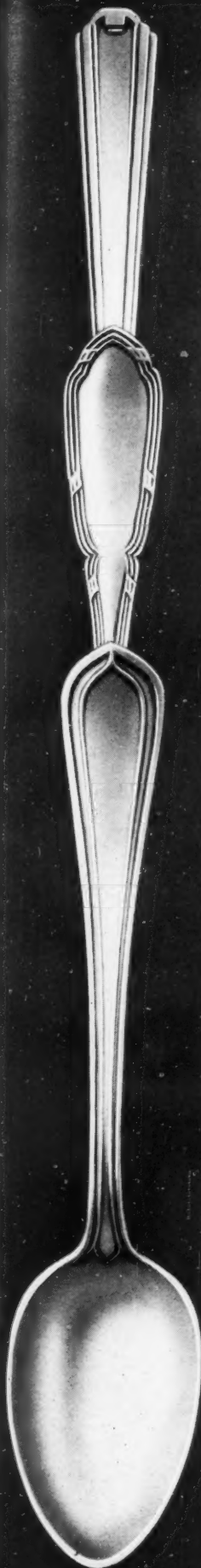


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The Hallmark of Quality





In Rabat is the beautiful Hôpital Marie-Feuillet, representative of the best of Moroccan architecture.

esting indeed. There are no traffic officers, but there seems to be one unwritten traffic regulation that applies to all of Africa — the donkey and the camel always have the right of way. The bazaars are small stalls opening directly on to the street. The owner of the stall usually sits on a hassock or squats beside the wall, waiting for customers to arrive. Frequently he may be seen in the corner of his shop taking his siesta. Morocco, it will be remembered, is the home of beautiful tooled leather goods. Brass work, pottery and handmade jewelry are also displayed frequently.

What the Moroccans Eat

Of special interest to us were the food shops. There are meat stalls where mutton, lamb and fowl are sold. Beef and veal are little used and pork is forbidden to the Moslem. Moroccan meat markets would not pass inspection based on our federal or state requirements. They are all entirely open, the meat hanging so that it can be seen at close range by passers-by. The same is true of fruits, vegetables and even bread.

We were indeed surprised to see the variety of vegetables and fruits used in these countries. Oranges, tangerines, dates, radishes, carrots, cauliflower, onions, leaks, potatoes, romaine, beans and some other vegetables unknown to us were seen in the markets. In the bread stalls the round loaves are piled one upon the other. The bread is sold in portions of loaves, although it is a staple article of diet. Needless to say, customers are at liberty to feel the cut surfaces of the bread to determine its freshness. Black olives in oil were frequently seen.

In certain streets there are native restaurants and coffee shops in abundance. These are fre-

quented only by the men. The coffee, of the Turkish variety, is always served black, frequently with fried pastry. The frying is done within a few feet of the narrow sidewalk where customers may come to buy. There are bake shops with the ovens just a few feet away from the sidewalk where the baker performs his work.

Cheese made of goat's milk is a staple article of diet. Goat's milk is the only milk available in this part of the world. Goats are driven through the streets of the native and the European sections of the city. The owner stops with his herd before his patron's house where the milking is done in full view of his customers. I saw one man, in order to level off a container that was a little too full for safe handling, pick up the can and drink some of the milk. The container was then delivered to his patron. The visitor comes to appreciate the goat, realizing the important part it plays in the sustenance of the population.

Water fountains, which are usually works of art, are licensed. The licensee is being permitted to sell the water, although he must give it to the poor. Around the fountains water venders fill their goat skins, which still seem to be the most convenient containers for carrying water in quantities. When a skin is filled, it is swung over the back with the neck hanging downward. When the neck is untied it makes a convenient spout, which is placed inside the mouth of the water jar for filling.

Veils and High Heeled Shoes Are Combined

One cannot properly discuss so romantic a country as Morocco without mentioning the dress of the inhabitants. The men wear long robes of white or colored cloth. The headgear usually consists of cloth wound about the head, although some wear the red fez. Women wear long white robes, and are closely veiled, sometimes with only one eye exposed, sometimes with both. With this native costume may now be seen French heeled shoes.

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Hospitals Welcome Its *Clean Profits*



Small—only 79 inches long. 2½ gallon capacity. Freezes ice cream in 13 minutes. Freezer, hardener, and mix storage all in one unit. Priced VERY LOW.

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Living conditions are similar in Algeria, Tunisia and Tripoli. The dress differs somewhat, but everywhere are seen the flowing robe, the veil for the women, and some kind of turban for the men. The bazaars and native quarters in Algiers and Tunis are covered so that they seem much darker and more "smelly" than those in the open streets.

Sees Site of Temple of Æsculapius

Carthage, near Tunis, was interesting historically. Here was pointed out the site of a temple to Æsculapius, the Greek god of medicine. Later in Athens we found statues of this god, as well as a temple to him, and the walls of a chemist's shop in Pompeii were decorated with the entwined serpents of Æsculapius. In the ruins of old Carthage we came upon snake charmers plying their trade for the benefit of tourists. The museum at Carthage reveals much of the life of this ancient city, with its huge wine cellars and many wine jars, which had been uncovered.

In southern Tunisia and inland about seventy-five miles is the walled native city Kairouan, said to be the most holy city in North Africa because of its numerous mosques and because it is the headquarters of the Mohammedan religion for North Africa. The Grand Mosque, about fourteen hundred years old, covers several acres. It surrounds a large court wherein are cisterns and a sundial. At the north end of this courtyard is the minaret from which the call to prayer is made five times a day.

About the court of this mosque are façades of marble pillars, three hundred and fifty of which came from the ruins of Carthage. As in all

mosques, the floors are covered with rugs. In this building they consist of matting. In some countries "infidels" are not permitted to enter a mosque under any circumstances. In others, foreigners may enter by removing their shoes or by putting over their shoes slippers provided by the mosque. In Kairouan, which seldom sees a tourist, slippers were not available. We were permitted to enter the mosque after the prayer rugs had been rolled back and we were requested not to touch them.

This building is lighted by chandeliers approximately twelve feet in height. They consist of hundreds of glass oil cups supplied with wicks, arranged in ever increasing circles about a central supporting structure.

Almost no women were to be seen on the streets that day and we were informed that they were kept in because of the large group of foreigners.

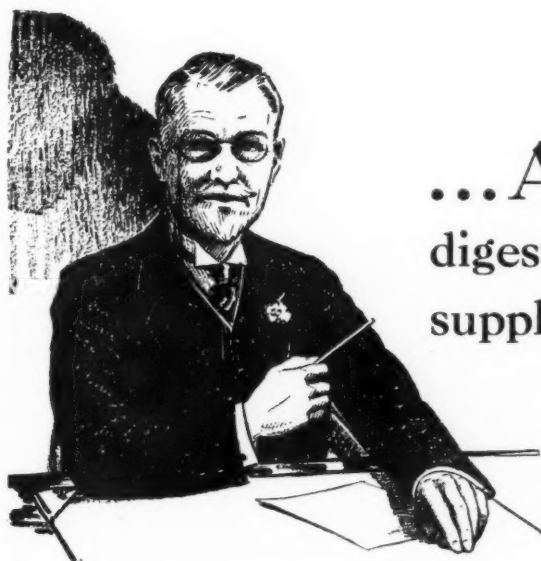
City of Tripoli Is Modern

Tripoli, now under Italian rule, is probably the most modern city in North Africa. The buildings are European in appearance and very beautiful. A ride over Italian paved roads, through the native quarters and through the country to the desert, revealed the progress being made by Italy. Hundreds of natives are now employed in crushing rock and in building roads and irrigation ditches. As we passed by the workmen smiled and frequently waved to show their friendly attitude toward the foreigner.

Egypt is still the land of mystery and romance. Historically there is little question but that it is the cradle of civilization. Its pyramids, built about five thousand years ago, without the aid of elec-



A native meat market in Tunisia. It would hardly pass inspection in this country.



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tricity or machinery, reveal the organizing ability of mankind even at this early date.

Aside from its antiquities, Egypt, especially Cairo, is interesting because of its cosmopolitan atmosphere, its unique bazaars, or mouski, its museum, mosques, splendid hotels, hospitals, schools and universities. One of the outstanding points of interest is the University of El-Azhar, said to accommodate thirteen thousand students from all parts of the Mohammedan world. This university is the center of political and religious thought of the Arabic peoples. It takes from ten to fifteen years to complete the course and to graduate with a diploma. The students are arranged in classes around an instructor who sits in a low chair while the students sit on the matting covered floor.

The underlying study of the university is that of the Koran, which the students are expected to

commit to memory. Some of the modern sciences are now being added to the course. Many of the students were doing their ablutions, preparatory to the call to prayer. These are sometimes done within the mosque, while in other countries they are done in the courtyard. The Moslem is required to bathe his face, neck, hands and arms to the elbow and his feet, three times each, before going to prayer. Even though bathtubs may be scarce, some of the physiologic requirements are met by this act.

An elementary school for boys was visited. The headmaster, educated in England, welcomed his unexpected guests with the courtesy of the old world. The boys, in neat khaki colored uniforms and wearing red fezzes, stood at attention and saluted. They were fine looking boys, ranging in age from eight to ten years. We were invited to watch their setting-up exercises. These exercises were taken just before noon lunch with all the precision of a military drill.

Lunch time arrived and, because of our interest in foods, we were invited to see the dining rooms and kitchen. The tables were neatly set with the necessary silver, napkins, china and water bottles. Bread and mandarins for dessert were also upon the table. Food was sent to the tables in sets of three filled containers for each table, one containing chicken, another rice, and a third a cooked vegetable. The kitchen was clean and equipped with tables, ranges and other simple equipment. Large tinned copper vessels were used for cooking.

It was our good fortune to have a letter of introduction to Dr. Shahin Pasha, physician to the king and secretary of the department of health. I was interested to learn of the effort of this department to educate the native population in regard to health matters. This was being done, I learned, through health centers and posters. The doctor stated that surveys had been made of the native dietary, which was found to be quite sufficient in calories. They were not quite so sure about the other constituents.

Next month I shall tell about our visit to a large charity hospital before going on to several eastern Mediterranean ports.

No. 3—Chapeau (Eugénie) Salad

By Arnold Shircliffe*



Pineapple
Apricot
Cream Cheese

Rubyettes
Green Pepper
Lettuce

ON A BASE of lettuce, place a slice of canned pineapple. Fill the center with cream cheese. Place a canned apricot on the cheese. Pipe a line of cream cheese around the apricot, or "crown" of the hat, making a rosette of the cheese at one side. Place several thin slices of green pepper in the rosette to represent a plume. Alternate slices of rubyettes and diamond shaped pieces of green pepper around the apricot, completing the hat. This makes an attractive and appetizing little Sunday salad.

*Author of the Edgewater Beach Salad Book.

A NATURAL AID
In Correcting
**Common
Constipation**
due to insufficient bulk

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Ry-Krisp
*Whole
Rye
Wafers*
•

BECAUSE they are both an efficient corrective and a tempting food, Ry-Krisp Whole Rye Wafers are doubly welcome in diets planned to relieve common constipation due to insufficient bulk.

The simple ingredients which give them their distinctive flavor—flaked whole rye, salt and water; the double baking which produces their brittle crispness, also give Ry-Krisp Whole Rye Wafers these distinctive advantages: (a) a high percentage of bran, for increasing secretion and peristalsis, (b) high pentosan and crude fibre content—both natural aids in producing normal bowel action, (c) low moisture content which gives them high absorptive power, and makes them valuable for increasing the bulk of the diet.

Moreover, patients readily adhere to the diet you prescribe when you include Ry-Krisp—simply because these wafers *taste so good* at meals and between meals. Literature and samples sent on request to professional people.



RALSTON PURINA COMPANY
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Buying Food for a Hospital*

By ANGELINE PHILLIPS

University Hospital, Omaha, Neb.

FOR some time it has been a recognized fact that the person responsible for the planning, preparation and service of food in any type of institution should have a voice in the food purchasing.

Whether the hospital dietitian actually does the buying is relatively unimportant; the real concern is whether she can get the quality of food that gives the most satisfactory net return, cost and flavor throughout the whole process of production and service. Dietitians and purchasing departments have come to understand the essential factors involved in good food purchasing and to recognize the necessity for intelligent cooperation if the hospital is to maintain a high quality food service. Administrative dietitians must be competent in the field of food economics and in the art of planning, producing and serving appetizing and nutritionally adequate menus.

The raw food budget at the University Hospital, Omaha, is set up for the new year on the basis of per capita meal cost over the last six or twelve months. If market prices are advancing a marginal increase is estimated. The number of patients is probably more stable here than in most hospitals, since the number available always exceeds the bed capacity. Food supplies are bought on two funds, supply and hospital maintenance. Supply covers all items stocked in the large storeroom and charged out as issued; hospital maintenance covers the perishable foods delivered daily. A 3 per cent handling charge covers all costs of receiving and issuing supplies.

Developing Food Specifications

Specifications for food purchasing develop from the qualities of food available under government grading, and from the results of our own kitchen food production. Standardization of recipes, control of portions and the appearance and consumption value of food are the bases for building up food specifications. Since definite sizes of fruit, net return and grades of canned goods determine portion costs, it is highly important that so-called special offers on the market are not snatched up without consideration. An oversize peach may be cut in quarters for combination fruit salads, but

a small size fruit in apricots or plums may yield actually a smaller number of portions per can and thus increase the portion cost. Every food item needs good specification. This applies to cocoa, rice, flavorings, cereals, flour, tea and other staples, as well as canned foods.

In order to visualize better the stock and its turnover, the dietary department assists in taking the storeroom inventory each month. Space and shelving in the storeroom are adequate and the food items are arranged in alphabetical groupings as they appear on the inventory form so that minimum time is required for checking. The foods are classified under cereals, fruits, vegetables, fish and miscellaneous groceries. The new requisition is entered on the inventory form and sent to the purchasing department the first week of the month. A portion of the inventory form is shown here.

<i>New Requisition</i>	<i>Food and Specification</i>	<i>June 1, 1934 Inventory</i>
25 cases	Apricots, halves, choice 55-60's	12 cases
10 cases	Whole with stones—choice 44-50's	6 cases

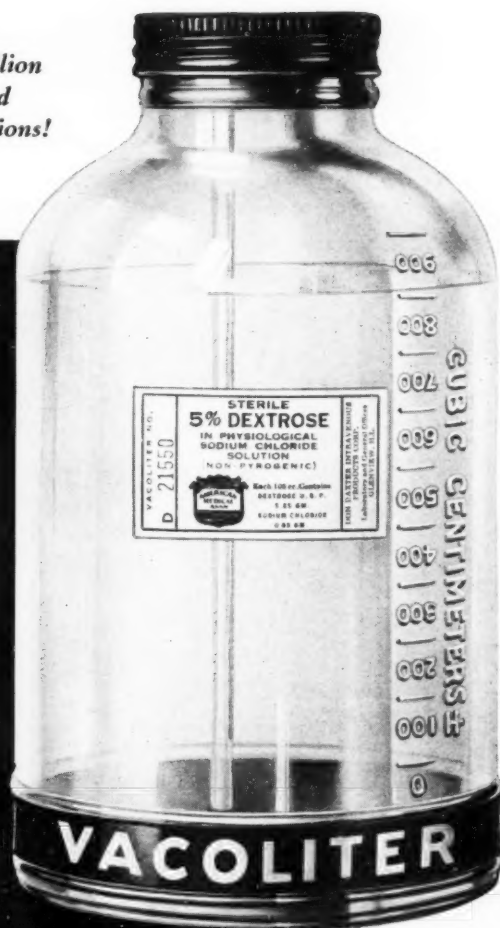
Copies of the new requisition are sent out to various firms with specifications. Firms are asked to name brands and submit samples whenever requested. The dietitian interviews salesmen the last week of the month by appointment and keeps in touch with current market conditions before these bids are sent out. This contact with the trade keeps the dietitian informed about new foods available or changes and improvement in grading. On the declining market of the last two or three years our policy has been to buy staples monthly, and to keep on hand only an exceedingly small surplus of canned goods.

When futures are to be bought selection will be made from a variety of grades submitted in duplicate so that a check can be made upon delivery. If cans are free from labels a more accurate, unprejudiced judgment can be made on quality during the selection testing. The bid goes to the best bidder, considering quality, flavor, appearance and portion costs. All bids are referred to the dietitian for her approval before orders are actually placed. A bill of delivery also comes to the dietitian. The quality is again checked and if not up to specifications the goods are returned for adjustment.

*One of a series of articles on food purchasing.

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liters and
no reactions!



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To you, of the Medical and Hospital profession of America, who have indicated and used one billion cubic centimeters of Baxter's Solutions, our thanks! And our pledge that Baxter's Solutions will continue to be the standard for the profession.

And to you,—who have not used Baxter's Solutions, won't you accept our invitation to enjoy the advantages of reaction-free, safe and economical Intravenous solutions?



"After using them I find that it actually costs less to buy them than it does to make our own solutions and certainly they are more uniform."

—Hospital in Oklahoma.

"They are now given as a routine to most surgical patients without the thought of a reaction. We never have one."

—Hospital in Texas.

"Since using Baxter's products we have never had a reaction. We have found the cost to be no more than the expenditure necessary in making our own solutions."

—Hospital in Illinois.

"Each Doctor who works in this hospital is most enthusiastic about this product and since we commenced using this they will have no other."

—Hospital in Kansas.

"Since we started using these preparations our post-intravenous reactions have disappeared, a fact that is also conducive to our peace of mind."

—Hospital in Minnesota.

"We have been using Baxter's Intravenous Solutions for the past two years during which time we have increased the efficiency of our post-operative care."

—Hospital in Wisconsin.

*The original letters from which these excerpts were taken are on file in our office with hundreds of others. Names will be furnished upon request.

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A perpetual card inventory of current food issues is kept in the purchasing department so that all information on storeroom supplies is available at any time. All prices are on file in the dietary department also, since duplicates of all orders are sent there daily with prices.

Ordering Meats, Fruits and Vegetables

Perishable foods on daily delivery are bought on hospital maintenance; milk, bread and ice cream are purchased on six-month contracts, and all other supplies are bought on weekly bids. Menus are made up one week in advance and the order for the week is submitted to the purchasing department on Saturday morning. Orders for the week are ready to be placed on Monday afternoon. One copy of the order is retained in the dietary department, one in the purchasing department, and one in the receiving storeroom. Items and weights are checked upon delivery and quality is checked as soon as delivery is made in the kitchen near-by.

Fruit and vegetable jobbers call once a week and submit prices based on as definite specifications as possible in sizes and weights. Per capita meat prices were found to be satisfactory when meat was bought in small and individual cuts instead of hotel cuts. The menus, of course, take into consideration the market conditions of the week. The following type of order is made up to cover the week, firms and prices being indicated.

June 5, 1934		Price	Firm
7 only native hens—5-6 lbs.		stated	stated
60 lbs. pork chops, 10-12 lbs. pork loin cut through		stated	stated
1 only sweet pickled ham—12-15 lbs. boned and rolled		stated	stated
20 lbs. bacon—6-8 lbs. sliced on No. 5		stated	stated
140 lbs. ripe watermelon		stated	stated
1 crate rough celery—3 doz.		stated	stated
5 lbs. green peppers		stated	stated
1 crate lemons—360's		stated	stated
2 crates oranges—252's		stated	stated
2—64-oz. boxes frozen green peas		stated	stated

The monthly food cost report is made up jointly by the dietary and the purchasing departments. Daily totals of supply items and hospital maintenance items are accessible each night to the dietary department and these costs are then entered on this simplified form for checking daily food costs.

Month	Date	Day	F-1	F-2	F-3	F-4	F-5	F-6	F-7	F-8	F-9	F-10	Total	No Meals	Meal Cost
June	1	Mon.													
	2	Tues.													
	3	Wed.													
	4	Thurs.													

F-1 Meat and poultry
F-2 Fish (fresh and canned)
F-3 Eggs
F-4 Milk, cheese, ice cream, cream
F-5 Butter

F-6 Fresh fruits and vegetables
F-7 Canned fruits and vegetables (dried)
F-8 Cereals and cereal products
F-9 Groceries
F-10 Fats

These daily costs with the meal census give a running daily cost that is easily kept and satisfactory for day to day comparisons. Over a period of a week this meal cost checks with the monthly cost. Overhead items of labor, gas, laundry, cleaning, supplies and repairs are added by the purchasing department.

For the period of the past year our patient census has approximated 160, and the number of staff and personnel having meals at the hospital has been about 150. The per capita raw food cost has run between \$.094 and \$.104 for the entire group, with an overhead of \$.057 per meal. This hospital has no private patient department and costs are not calculated separately for staff and patients.

The following percentage distribution of expenditures is representative: meat, 22.6 per cent; eggs, 5.9 per cent; milk, 21.4 per cent; fruit and vegetables, 26.6 per cent; fats, groceries and cereals, 23.5 per cent.

The guide sheets of the American Dietetic Association have been helpful in working out the classification of food items on a ledger sheet. Per capita consumption of food after further study will become another check on the adequacy of our hospital food.

Storeroom Stock Keeping Must Be Systematic

In any institution having a centralized purchasing department, food purchasing can be made highly satisfactory if the dietitian works out carefully the specifications for food purchases, and the purchasing department buys on this basis. The dietitian who is relieved of the details of record keeping has time to supervise food during its entire production and service. The facts she finds can be definitely presented so that they are useful in developing better judgment in purchasing.

There must also be a systematic method of keeping the storeroom stock supplied so that it is not necessary to substitute on the menus when stock runs low. When higher grade foods are substituted for lower grade needs, costs increase; when lower grade foods are substituted for higher grades, quality of the finished product is inferior.

A printed form on which are entered the daily costs of food supplies at the University Hospital, Omaha.



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September Dinner Menus for the General Hospital Patient*

By GLADYS SPRING RAMBLER
Administrative Dietitian, Harper Hospital, Detroit

Day	Appetizer or Soup	Meat or Substitute	Potato or Substitute	Vegetable	Salad or Relish	Dessert
1.	Consommé	Roast Beef	Duchess Potatoes	Buttered String Beans	Tomato and Lettuce	Cantaloupe
2.	Tomato Juice Cocktail	Roast Chicken, Dressing	Mashed Potatoes	Buttered Peas	Avocado	Ice Cream, Fudge Sauce
3.	Ministra	Baked Pork Chops	Escalloped Potatoes	Buttered Spinach	Perfection	Apple Sauce and Whipped Cream, Ginger Bread
4.	Fresh Fruit Cocktail	Sirloin Steak	Lattice Potatoes	Braised Carrots	Spiced Pear With Cream Cheese	Cherry Tarts
5.	French Onion Soup	Broiled Veal Cutlets	Potatoes au Gratin	Harvard Beets	Combination Vegetable	Banana Ice Cream
6.	Philadelphia Pepper Pot Soup	Roast Lamb, Mint Sauce	Baked Potatoes	French Fried Egg Plant	Head Lettuce, Sherry Dressing	Prune Whip, Ice Box Cookies
7.	Cream of Celery Soup	Steamed Halibut, Dugliere Sauce	Parsley Potatoes	Buttered Cabbage	Fresh Fruit	Charlotte Russe
8.	Consommé	Roast Pork	Escalloped Potatoes	Buttered Broccoli	Carrot and Raisin	Apple Turnover
9.	Cream of Chicken Soup	Chicken Pie	Buttered Rice	Buttered Cauliflower	Tomato and Cucumber	Raspberry Sherbet
10.	Pineapple Juice With Mint	Broiled Lamb Chops	Rissole Potatoes	Stuffed Baked Onions	Prunes With Cottage Cheese	Fresh Peach Tart, Whipped Cream
11.	Cream of Mushroom Soup	Baked Ham	Glazed Sweet Potatoes	Escalloped Tomatoes	Romaine With Roquefort Dressing	Apricot Upside Down Cake, Custard Sauce
12.	Grapefruit Cocktail	Tenderloin Steak	Julienne Potatoes	Baked Squash	Chef's	Date Torte, Whipped Cream
13.	Navy Bean Soup	Roast Veal, Dressing	Buttered Noodles	Mashed Rutabagas	Spiced Pineapple and Cream Cheese	Rice Fluff
14.	Clam Chowder	Salmon Steak	Baked Potatoes	Braised Celery	Gingerale	Chocolate Mint Ice Cream
15.	Vegetable Soup	Beef à la Mode	Rissole Potatoes	Corn on the Cob	Waldorf	French Pastry
16.	Cranberry Juice Cocktail	Chicken Maryland	Mashed Potatoes	Buttered Brussels Sprouts	Head Lettuce, Russian Dressing	Black Walnut Ice Cream
17.	Consommé	Baked Pork Chops	French Fried Sweet Potatoes	Grilled Tomatoes	Cottage Cheese and Olive	Peach Shortcake
18.	Split Pea Soup	Roast Beef	Baked Stuffed Potatoes	Mashed Summer Squash	Marshmallow, Date and Nut	Cantaloupe
19.	Orange Juice	Broiled Lamb Chops	Duchess Potatoes	Buttered Spinach	Banana-Nut	Lemon Torte
20.	Cream of Tomato Soup	Breaded Veal Cutlets	Buttered Noodles	Braised Parsnips	Beet and Pickle	Angel Food With Ice Cream and Raspberry Sauce
21.	Barley Soup	Baked Stuffed White Fish	Parsley Potatoes	Broccoli, Hollandaise Sauce	Fresh Fruit	Chocolate Brownies With Whipped Cream
22.	Cream of Pea Soup	Broiled Steak, Mushroom Sauce	French Fried Potatoes	Buttered String Beans	Avocado and Grapefruit	Pineapple Bavarian
23.	Grapefruit and Gingerale Cocktail	Roast Duck, Dressing and Cranberry Sauce	Mashed Potatoes	Baked Squash	Stuffed Tomato	Orange Sherbet
24.	Chicken Noodle Soup	Chicken à la King in Patties	Buttered Rice	Grilled Green Tomatoes	Combination Vegetable	Boston Cream Pie
25.	Corn Chowder	Baked Ham	Baked Sweet Potatoes	Vichey Carrots	French Endive, Sherry Dressing	Fruit Cup, Coconut Kisses
26.	Mint Cocktail	Roast Veal, Dressing	Duchess Potatoes	Buttered Peas	Orange and Coconut	Cream Puff, Fudge Sauce
27.	Okra and Tomato Soup	Tenderloin Steak	Julienne Potatoes	Buttered Onions	Head Lettuce, Thousand Island Dressing	Pistachio-Nut Ice Cream
28.	Oyster Stew	Fillet of Sole, Tartar Sauce	Baked Stuffed Potatoes	Harvard Beets	Perfection	Steamed Pudding, Hard Sauce
29.	Cream of Vegetable Soup	Swiss Steak	Rissole Potatoes	Hot Slaw	Fresh Fruit	Lemon Tarts
30.	Consommé	Roast Chicken, Dressing	Mashed Potatoes	Buttered Brussels Sprouts	Grapefruit and Cream Cheese	Buttercrunch Ice Cream

*Recipes for any of the foregoing dishes will be supplied upon request by Anna E. Boller, Central Free Dispensary, Rush Medical College, Chicago.

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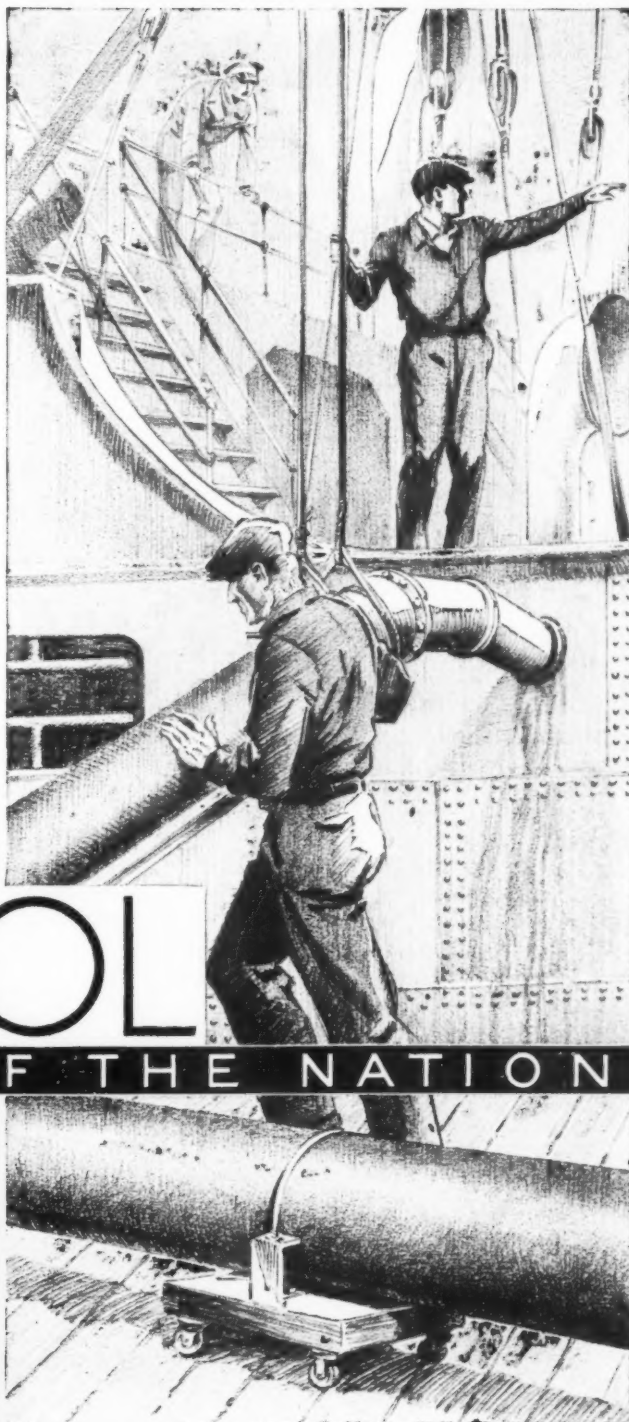
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NEWS OF THE MONTH

Protestants Plan Practical Convention Designed to Aid Both Large and Small Hospitals

A program featured as usual by a large number of round table discussions in which all may partake has been prepared for the fourteenth annual convention of the American Protestant Hospital Association, which will meet in the Bellevue-Stratford Hotel, Philadelphia, September 21 to 24, inclusive.

The meeting is to be called to order on Friday afternoon, September 21, by the president, Charles S. Pitcher, former superintendent, Presbyterian Hospital, Philadelphia. The first address is by Bryce L. Twitty, superintendent, Baylor University Hospital, Dallas, Texas, on "Some of the Most Pressing Problems of Our Hospitals."

This will be followed by an hour's discussion of nursing in which Miss Grace B. Hinckley, superintendent, Methodist Episcopal Hospital, Brooklyn; J. B. Franklin, superintendent, Grady Hospital, Atlanta, Ga.; Rev. A. O. Fonkalsrud, superintendent, Mansfield General Hospital, Mansfield, Ohio; E. R. Snyder, Wesley Memorial Hospital, Chicago, and T. J. McGinty, superintendent, Southeast Missouri Hospital, Cape Girardeau, Mo., will participate.

Following this will be a round table discussion in which a large number of delegates will participate briefly.

Finance Committee Will Report

The Friday evening session will be devoted primarily to the presidential address by Mr. Pitcher. Other speakers will be Dr. Joelle C. Hiebert, superintendent, Central Maine General Hospital, Lewiston, Me., on "Ethical Service in Hospital Practices" and Dr. Stanley P. Reimann, director, Wanamaker Research Department, Lanekau Hospital, Philadelphia.

The finance committee's report will be the first event on Saturday morning's program. Rev. John Martin, superintendent, Hospital of St. Barnabas and for Women and Children, Newark, N. J., will speak on "The Rebuilding of Our Constitution."

This will be followed by a two-hour round table on "The Hospital's Medical Practice and Administrative Prob-

lems." The round table will be conducted by Robert Jolly, superintendent, Memorial Hospital, Houston, Tex. A large number of delegates have been asked to participate in the discussion.

May A. Middleton, superintendent, Methodist Episcopal Hospital, Philadelphia, will open the Saturday afternoon session with a paper, "The Out-Patient Department." E. I. Erickson, superintendent, Augustana Hospital, Chicago, will speak on "The University Training of Hospital Executives."

Dr. Bert W. Caldwell, executive secretary, American Hospital Association, will speak on "What Is the Educational Obligation of the Hospital to Its Physicians and Interns?"

The next event on the program will be a round table discussion of questions taken from the question box. Paul Fesler, superintendent, Wesley Memorial Hospital, Chicago, will be in charge, assisted by the past presidents of the association.

Doctor Faxon Will Speak

The annual banquet will be held on Saturday evening, with President Pitcher presiding. Dr. Nathaniel W. Faxon, director, Strong Memorial Hospital, Rochester, N. Y., and president of the American Hospital Association, will be one of the principal speakers.

The next session will be held on Sunday afternoon. John A. McNamara, director, Cleveland Hospital Service Corporation, will lead a discussion entitled "Let's Talk About Our Problems." This will be followed by an open forum on "The Responsibility of Protestant Christianity for Hospital Care," conducted by Dr. Charles C. Jarrell, Atlanta, Ga., president-elect of the association.

The final session will be held on Monday morning. The first event on the program will be the introduction of the editors of magazines in the field, as follows: Mary Roberts, editor, *American Journal of Nursing*; Meta Pennock Newman, editor, *Trained Nurse and Hospital Review*; Alden B. Mills, managing editor, *The Modern Hospital*, and M. O. Foley, managing editor, *Hospital Management*.

"The Purpose of the American College of Hospital Administrators" will be discussed by J. Dewey Lutes, director general of the college and superintendent of Ravenswood Hospital, Chicago. Robert E. Neff, administrator, University of Iowa Hospital, Iowa City, Iowa, will speak on "Utilitarian and Practical Needs of the Hospital."

The final event will be a round table conference on "Maternal Care in General Hospitals." The round table will be conducted by Dr. Malcolm T. MacEachern, director of hospital activities, American College of Surgeons, assisted by a number of hospital executives.

Institute Registration Continues to Increase

The Institute for Hospital Administrators apparently is going to attract a larger attendance this year than last. Although the American Hospital Association announced that the registration would be limited to 75 persons, the demand was so great that a total of 129 registrations had been received and accepted on August 22. The institute will open at the University of Chicago on September 10 and continue through September 22.

Minimum Wage Scale Set for Hospital Laundries

The attorney general of Ohio has ruled that hospital laundries in the state must adhere to the Minimum Fair Wage Standards governing women and minors working in laundries, in accordance with Mandatory Order No. 1 of the Ohio Department of Industrial Relations. In many cases, it is stated, the attorney general's ruling means that hospitals in the state will be required to increase their laundry wage scales.

Following are the minimum wage scales for women and minors (all workers under twenty-one years of age) as specified in Mandatory Order No. 1:

Basic rate for a full work week of 40 hours—27½ cents per hour, or \$11 per week.

Payment for undertime for a week of less than 20 hours—30¼ cents per hour, or 10 per cent added to 27½

*

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*

*

NEWS OF THE MONTH

cents per hour for a week of less than 19 hours, and 29 cents per hour for a week of 19 hours. (A bonus of 10 per cent shall be added to the basic rate per hour, until the wage paid for the week's work is equal to the wage paid for 20 hours of work.)

Payment for overtime for a week of more than 40 hours—For the first five hours beyond the basic 40 hours, the basic rate shall be paid, or 27½ cents per hour. Time and a third rates shall be paid for each hour after the 45th, or 37 cents per hour (or 33 1/3 per cent added to 27½ cents per hour).

The administrative regulations of Mandatory Order No. 1 cover piece-work, minors and learners, physically handicapped workers, waiting time, statement to employee, payment of wages, records and certificate of age.

Hospitals have been granted special permission to pay their laundry workers twice a month instead of weekly, according to A. E. Hardgrove, executive secretary, Ohio Hospital Association. They are also allowed to use their own record forms instead of those prescribed by the director of industrial relations.

New Hospital Will Be Built in Jerusalem

Mount Scopus in Jerusalem will be the scene of the first medical center and graduate school of medicine in Palestine. It will be known as the Rothschild-Hadassah-University Hospital, and its location is near the Hebrew University.

Site of Civil War Hospital Is Marked

A bronze tablet has been placed on a worn boulder on Chimborazo Hill in Richmond, Va., according to the *Journal of the American Medical Association*, marking the site of Chimborazo Hospital, said to have been the largest military hospital in the world during the Civil War.

The hospital consisted of 150 wooden buildings and cared for a total of 76,000 patients during the war. The commandant of the hospital was Dr. James B. McCaw, father of Brig. Gen. Walter D. McCaw, for many years librarian of the Army Medical Library.

Nightingale Memorial Is Founded in London

The Florence Nightingale International Foundation was inaugurated at a recent meeting in London, England. The meeting was held under the chairmanship of Sir Arthur Stanley, and delegates of nursing societies from all parts of the world were in attendance.

Officers were elected from the countries of the world. Adelaide Mary Nutting, emeritus professor at Columbia University, was named honorary presi-

dent of the foundation. Among the vice presidents elected were Mrs. William K. Draper, American Red Cross Society; Annie Warburton Goodrich, Yale University School of Nursing, and Jean Gunn, superintendent of nurses, Toronto, General Hospital, Toronto, Ontario, Can.

The purpose of the foundation is to provide postgraduate nursing education on a permanent basis for a selected group of fully trained nurses, drawn from those in the forefront in all civilized countries in the world.

New Hospital Yearbook Ready Next Month; Contains Latest Original Reference Data

Something new in reference books will soon be available to hospital administrators, purchasing agents, department heads, architects, engineers and consultants. A volume that promises to serve the hospital man as the World Almanac, for example, serves the newspaper copy editor—as a desk book never out of reach—will be off the press in October.

The HOSPITAL YEARBOOK is its name and it is the thirteenth edition of the familiar but not always well utilized MODERN HOSPITAL YEARBOOK. So changed is the book in form and content that the publishers have decided on the new name.

In principle the book follows the World Almanac and other books of fact for general usage. Almost everything is in list form. There is a minimum of straight text matter, a minimum of illustrations. Tables, charts and forms as guides to purchasing, operation and equipment have replaced pleasing but unnecessary reproductions of hospital exteriors.

A total of 200 pages of editorial material largely of check list nature will appear in the volume—not scattered throughout the book under arbitrary divisions, but logically arranged at the beginning.

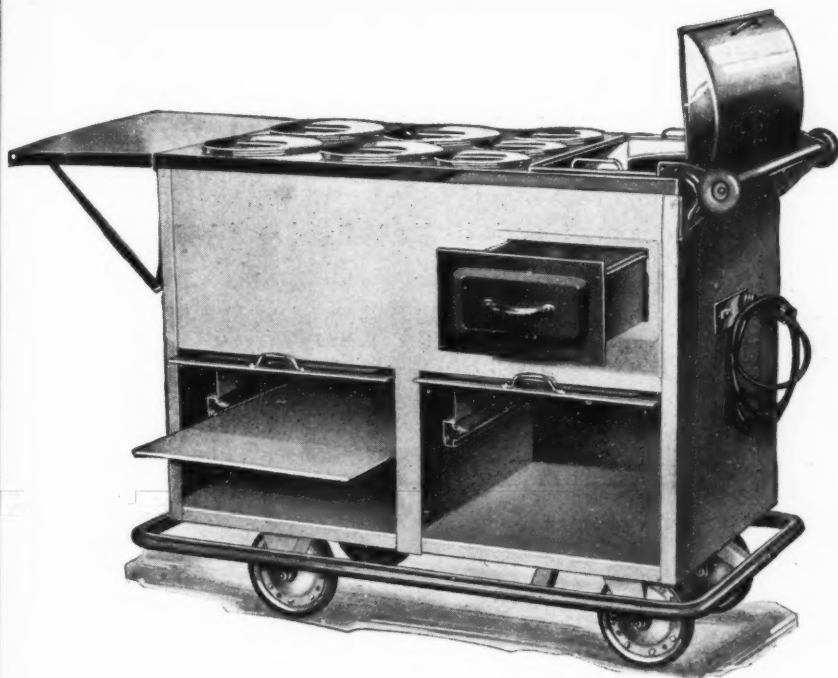
"If properly utilized, this book will save the hospital world a great deal of time, worry and money," declares Alden B. Mills, the editor. "Before writing around to authorities or to other institutions for specific information hospital superintendents and others should consult The HOSPITAL

YEARBOOK, not using their valuable time for research and reply. The answer is probably in The HOSPITAL YEARBOOK, and it is easy to find.

"Most of the material appears in print for the first time. That part of it which has been published previously will appear in the new yearbook with 1934 revisions made by the original authors. The list of contributors is much like the list of speakers at a national hospital convention, except that in this reference book they have concentrated their knowledge in skeleton form for ready reference."

A complete buying guide of hospital products and commodities will make up an equally valuable part of the volume. The third and final section is filled with catalogues from firms supplying the hospital field.

Authorities who have contributed to the 1934 HOSPITAL YEARBOOK include Dr. S. S. Goldwater, Dr. Lucius R. Wilson, Carl A. Erikson, Dr. C. W. Munger, Dr. Fred G. Carter, Dr. D. L. Richardson, Dr. S. A. Levinson, Dr. John Coulter, H. Eldridge Hannaford, Dr. Joseph C. Doane, William J. Overton, John R. Mannix, Sidney G. Davidson, C. Rufus Rorem, Robert Jolly, Alfred Meyer, Le Roy A. Ayer, Dr. Walter E. List, Dr. Basil C. MacLean, Herbert R. Sands, Charles F. Neergaard, John C. Dinsmore, Perry W. Swern, George W. Booth, Dr. Morris Hinenburg, Mary W. Northrup, Dr. Herman Smith, Miss E. N. Ylvisaker, Ada Belle McCleery, Joseph J. Weber, Edward F. Stevens, Miss F. Walkenhauer and Mrs. Doris L. Dungan.



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NEWS OF THE MONTH

Indiana Hospitals and Health Agencies to Meet

Paul V. McNutt, governor of Indiana, will be the principal speaker at the opening session of the meeting of the Indiana Hospital Association on October 8. The meeting will be held at the Lincoln Hotel, Indianapolis, in conjunction with all health agencies in the state.

The state medical association, nurses' association, dental association, tuberculosis association, hospital association and all other associations will meet simultaneously on October 8. This meeting will be held the day preceding the opening of the convention of the Indiana Medical Association.

Hospital Is Burned

The Grenfell orphanage and school at Cartwright, Labrador, which served as a hospital for the district and for the northern fisheries, was burned recently with the loss of one life. The institution was erected four years ago at a cost of approximately \$100,000.

Construction Resumed at Biggs Memorial Hospital

The work of completing the defaulted contract for general construction of the Hermann M. Biggs Memorial Hospital, Ithaca, N. Y., has been awarded to Wills, Taylor and Mafera Corporation, New York City. The contract in the sum of \$397,397 was signed recently, and it is expected that the hospital will be completed soon.

Student Plan Favored for Kings County Hospital

A student division for Kings County Hospital, Brooklyn, N. Y., through affiliation with Long Island Hospital is planned by Dr. S. S. Goldwater, commissioner of hospitals, New York City.

Doctor Goldwater has received a report from a committee named by him to make a study of the situation. One plan is for the establishment of two separate medical divisions under one board, one a teaching and the other a nonteaching division. Doctor Goldwater said he favors this over the al-

ternative plan of two separate medical boards.

The idea of the committee is that members of the visiting staff, many of them associated with the college of medicine, be invited to act as instructors.

"Through its college affiliations," said Doctor Goldwater, "Bellevue Hospital has enjoyed advantages denied to other departments. A teaching hospital is on its mettle as to scientific work, clinical records, medical social service and nursing care."

In its report the committee recommended that 455 beds be used for teaching purposes. This represents about one-sixth of the total number in the hospital and would include a large percentage in the more active medical and surgical wards. Among the services proposed for inclusion in the teaching division are medicine, surgery, pediatrics, obstetrics and gynecology.

Before the recommendations can take effect they must be passed upon with approval by the advisory council of the department. Commissioner Goldwater said he hoped the proposed teaching division in the Kings County Hospital would be in operation by fall.

Begin Building \$5,000

Hospital for Quintuplets

Early in September the Dionne quintuplets will have a hospital all their own—a hospital costing \$5,000, upon which work was commenced on August 9, 100 yards from the Dionne home, near Callander, Ont. It will be a complete baby hospital in miniature. The government is cooperating in the extension of electricity service and in building a road, and the royal Canadian mounted police may provide a guard.

Dr. Alan R. Dafeo, who is in charge of the quintuplets, chose a country site for the institution in preference to a town site in Callander. A germ from the smoke and dirt ridden town air, Doctor Dafeo said, might end the lives of any one of the quintuplets. He regards the pure, clear air of the timbered area as giving advantage over any settled district.

It costs more than \$150 a week, Doctor Dafeo estimates, to maintain the infants, who are now, in effect, wards of His Majesty King George. Crown authorities have been given oversight of the Dionne children for two years.

Coming Meetings

American Public Health Association.

President, Dr. Haven Emerson, New York.
Executive secretary, Dr. Kendall Emerson, 50 W. 50th Street, New York.
Next meeting, Pasadena, Calif., Sept. 3-6.

American Protestant Hospital Association.

President, C. S. Pitcher, Philadelphia.
Executive secretary, Dr. Frank C. English, 3233 Griest Avenue, Cincinnati.
Next meeting, Philadelphia, Sept. 21-24.

American College of Hospital Administrators.

Director-General, J. Dewey Lutes, Ravenswood Hospital, Chicago.
Next meeting, Philadelphia, Sept. 23.

American Hospital Association.

President, Dr. Nathaniel W. Faxon, Strong Memorial Hospital, Rochester, N. Y.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, Philadelphia, Sept. 24-28.

American Occupational Therapy Association.

President, Dr. Joseph C. Doane, Jewish Hospital, Philadelphia.
Secretary-Treasurer, Mrs. Eleanor Clarke Slagle, Room 1511, 175 Fifth Avenue, New York City.
Next meeting, Philadelphia, Sept. 24-28.

Indiana Hospital Association.

President, E. C. Moeller, Lutheran Hospital, Fort Wayne.

Secretary, Albert G. Hahn, Protestant Deaconess Hospital, Evansville.
Next meeting, Indianapolis, Oct. 8.

Ontario Hospital Association.

President, R. F. Armstrong, Kingston.
Secretary-Treasurer, Dr. Fred W. Routley, 410 Sherbourne Street, Toronto.
Next meeting, Toronto, Oct. 10-12.

American Dietetic Association.

President, Quindara Oliver Dodge, Simmons College, Boston.
Business manager, Dorothy I. Lenfest, 185 North Wabash Avenue, Chicago.
Next meeting, Washington, D. C., Oct. 15-18.

American College of Surgeons.

President, Dr. Wm. David Haggard, Nashville, Tenn.
Executive secretary, M. T. Farrow, 40 East Erie Street, Chicago.
Next meeting, Boston, Oct. 15.

Association of Record Librarians of North America.

President, Evelyn M. Vredenburg, Woman's Hospital, New York City.
Corresponding secretary, Alice G. Kirkland, Samuel Merritt Hospital, Oakland, Calif.
Next meeting, Boston, Oct. 15.

Kansas Hospital Association.

President, John E. Landers, Wesley Hospital, Wichita.
Secretary, Dr. John T. Axtell, Axtell Christian Hospital, Newton.
Next meeting, Newton, Oct. 27.

• **AMERICAN HOSPITAL** •

ASSOCIATION CONVENTION

PHILADELPHIA

SEPT. 24-28



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NEWS OF THE MONTH

State Health Insurance Plan for Canada Is Proposed by Medical Assn. Committee

A plan of state health insurance for Canada has recently been published by the committee on economics of the Canadian Medical Association and is being discussed by the provincial medical associations.

The report of the committee is a statement of principles rather than administrative details. It is the outgrowth of work started in 1929, the present committee being given this task in 1932. Dr. W. Harvey Smith, Winnipeg, is chairman of the committee and Dr. A. Grant Fleming, Montreal, is secretary.

The Proposed Principles

A set of seventeen principles proposed by the committee effectively summarizes the plan. These are:

1. That, in the provinces where state health insurance is established, it be administered by the departments of public health in order to coordinate the organized preventive and curative medical services.

2. That a central health insurance board and local insurance boards be appointed, representative of all interested parties, to advise the responsible administrative authority.

3. That the professional side of health insurance medical service be the responsibility of the organized medical profession through the appointment, by the medical societies, of a central medical services committee and local medical services committees to consider and advise on all questions affecting the administration of the medical benefit.

4. That local areas for health insurance administration correspond to urban municipalities and rural health unit areas.

5. That the whole province be served by adequate departments of public health, organized on the assumption that individual health supervision will be provided by the health insurance general practitioner.

6. That there be a state health insurance fund, provincially controlled, and that "regional officers," to act as supervisors and referees, be appointed, paid and controlled by the provincial department of public health.

7. That the medical care for indigents be provided under the plan, the state to pay the premiums of the indigent, who then receive medical care under exactly the same conditions as the insured person.

8. That the plan be compulsory for persons with dependents having an income of less than \$2,500 a year and for persons without dependents having an income of \$1,200 or less a year.

9. That the dependents of insured persons be eligible for the medical benefit.

10. That there be offered on a voluntary basis to those with incomes above the health insurance level, hospital care insurance, and that this be administered as part of the plan.

11. That the only benefit under the plan be the medical benefit.

12. That the medical benefit be organized as follows:

(a) Every qualified licensed practitioner to be eligible.

(b) Insured to have free choice of general practitioner.

(c) Medical service to be based upon making available to all a general practitioner service for health supervision and the treatment of disease.

(d) Additional services to be secured normally through the general practitioner; specialist and consultant medical service from lists of eligible specialists and consultants; visiting nurse service in the home; hospital care; auxiliary services (usually in the hospital), and pharmaceutical service.

(e) Dental service, arranged direct with dentist or upon reference.

Other Principles

13. That the insurance fund should receive contributions from the insured, the employers of the insured, and the state (both province and dominion).

14. That the medical practitioners of each local area be remunerated according to the method of payment which they select (salary, per capita, or fees).

15. That the central medical services committee decide the relationship

between specialist and general practitioner fees and between medical and surgical fees.

16. That contract-salary service be limited to areas with a population insufficient to maintain a general practitioner in the area without additional support from the insurance fund.

17. That no economic barrier be imposed between doctor and patient but that the insured be required to pay a part of the cost of medicines.

Arkansas Council Plans Legislative Program

Steps were taken at a recent meeting of the Arkansas Hospital Council to effect consolidated efforts of the legislative committees of the Arkansas medical, hospital, dental and pharmaceutical organizations.

At a recent meeting of the four major organizations' legislative committee heads basic plans for united action were adopted. Each organization is submitting to a central office the names of its leaders in each county. These persons will be in charge of the legislative work in the county.

The two main objectives of the legislative committees are defense against laws inimical to the best interest of medicine, hospitals, dentists and druggists; and to attempt to enact laws beneficial or to amend existing laws to fit existing conditions.

Establishes Midwifery Course for Graduate Nurses

A one-year course in midwifery has been established at Maternity Hospital, Philadelphia, for the benefit of graduate nurses preparing themselves for missionary work abroad or in isolated sections of this country. The course as planned is intensive and designed for nurses possessing superior qualifications, according to John N. Hatfield, superintendent.

Medical Staff Approves Group Hospitalization

The medical staff of Emory University Hospital, Atlanta, Ga., at a recent meeting unanimously approved group hospitalization.

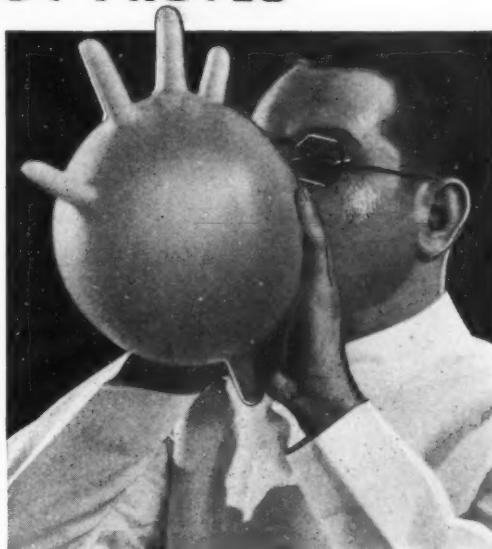
THE "One-Puff-Test" PROVES MATEX ARE THE MOST Comfortable

Glove comfort is directly dependent on the resilience of the rubber structure. A hard-stretching glove is responsible for glove cramp. A flabby, lifeless glove decreases the tactility of the fingers. The really comfortable glove clings to the hand like a second skin, is the most resilient. And here's a simple, easy way to select comfortable gloves. Grasp the wrist of a glove in your hand. Take a deep breath—NOW—blow one-puff into the glove. Notice how little resistance and how easily the glove expands to ordinary lung pressure. Do this with as many brands or makes as you care to. Then choose the glove that inflates easiest, for that one is the most resilient and therefore the most comfortable—Look for the name on the wrist and you'll unquestionably find the Trademark "Matex Dermatized."

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The improved J & J Shock Absorbing caster marks a new era in caster perfection. It embodies every improvement known to engineering skill.

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The CROSS OF HOPE



The year 1665 found disease rampant in England—taking heavy toll in human life. Terror-stricken people locked themselves in disease-ridden homes, all hope in medical aid lost. Fearfully, they nailed to the door a cross, and above it wrote the imploring words, "Lord Have Mercy on Us."

Contrast the pitiful helplessness of the Great Plague with the manner of combating disease today. Science now wages relentless warfare upon dirt and germs with Cleanliness, and its greatest weapons in this fight are Huntington Floor Soaps.

Each Huntington floor cleanser is recommended for a particular type of flooring. Each is safe; each is economical. But what is more important, wherever Huntington soaps are used, dirt cannot exist.



We maintain a special Floor Maintenance Laboratory to help you with your cleaning problems. Tell us the kind of floor you have, and we will tell you how to maintain it, efficiently, economically. Write

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The HUNTINGTON LABORATORIES Inc.

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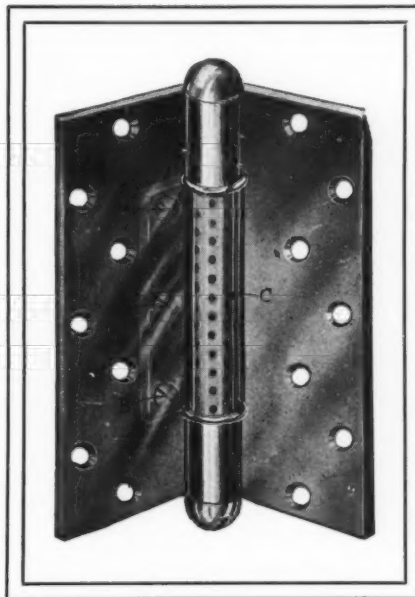
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New hospitals are being built with Rixson Friction Hinges on every interior door (except those usually controlled by Rixson Floor Checks). Hospitals being modernized can also assure themselves of this great protection against slamming doors, or doors that swing and squeak in a draft, or pound against an inflexible stop. Have your architect specify Rixson Friction Hinges in your hospital. Ask him to explain their durable construction.

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Next time you purchase sheets, remember this expert testimony. You will find Anchor sheets snowy, soft and smooth, with wide tape selvages and firmly stitched, well tailored hems. You will also find, as you gradually replace entirely with Anchor sheets, that replacements get farther apart, and your linen overhead grows less. That is why Anchor brand is used in so many of the country's largest and finest hotels and hospitals.

*Mr. Lee manages the five Blue Ribbon Hotels, The Brewster, Franconia, Bancroft, Cameron, Standish Hall, and other New York hotels famous for guest comfort.



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BOOKS ON REVIEW

SEEING AND HUMAN WELFARE. By Matthew Luckiesh, D.Sc., Director, Lighting Research Laboratory, General Electric Company. Baltimore: Williams & Wilkins Company, 1934. \$2.50.

This book is a plea for the development of a new "science of seeing." Such a science, the author states, would deal with "three major complexities which are interdependent and to some extent intermingled." They are (1) the external world of physical factors; (2) the eyes, visual sense and successive events of visual response, and (3) the psycho-physiological effects pertaining to human behavior, efficiency, welfare and happiness. This science would, if properly applied to human problems, mean greatly increased lighting on most close work, better sizes of type in printing, room decoration that would be more restful to the eyes and other similar reforms, the author states.

Mr. Luckiesh declares that present ideas of adequate lighting for indoor work are based on habits developed when the first incandescent lights were introduced. He criticizes many of the studies that have been made of the relation of light intensity to industrial output as being inconclusive. They merely show that marked increases of production do not result from increasing illumination beyond certain minima. "There is neither logic nor humanity in the conclusion that seeing-conditions cannot be improved beyond that point at which the natural maximum speeds of the worker's hands, arms, body, eyes, reactions and mind have reached."

The book is written in a nontechnical and interesting style for popular consumption. It is based on research which the author has carried on for a number of years under the sponsorship of the General Electric Company. —ALDEN B. MILLS.

A REVIEW OF NURSING. By Helen F. Hansen, R.N., A.B., M.A. Philadelphia: W. B. Saunders Company, 1934. Pp. 635. \$3.

This book offers a systematic review of subjects included in the nursing curriculum. It accomplishes this (1) by giving a section to definitions of terms frequently used in the subject, (2) by listing of synonyms, tables and charts under appropriate subjects, (3) by classifying and outlining the subject matter, including concise explanations, and (4) by introducing a series of objective questions. Four types of questions are used—matching, completion, true-false and single or multiple choice. Space is allowed for answers and correct answers are given in the back of the book. Approximately one-half the book is devoted to this material.

This type of book is new. Its aim is not only to prepare students for state board examinations but also to give them a view of each subject as a whole and in relation to other subjects. The outlines and questions may be helpful to instructors in choosing where emphasis should be put.

There is danger that the brevity of the outlines and limitations of the questions may give the student a false feeling of satisfaction that she knows sufficient about the subject. The use of true-false questions involves guessing and bad psychology.

The book represents a great deal of work and will find a place in nursing libraries.—LOULA E. KENNEDY.

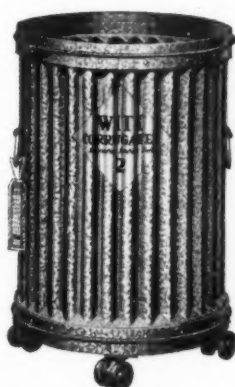
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CUT CAN COSTS

In many of the leading hospitals, purchase records show that WITT CANS out-last from 3 to 5 of the ordinary kind.

Sanitary Food Storage

WITT CANS are ideal containers for the safe and sanitary storage of food supplies—flour, cereals, coffee, beans, etc. Because of exclusive features and improved construction they are air-tight, dust-tight, moisture-proof.



WITT CANS are made in all styles and sizes to meet all requirements.

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For the safe and sanitary disposal of ashes and garbage, WITT CANS are most economical.

Made stronger, they last longer. Tests at the Pittsburgh Testing Laboratory have definitely proved that WITT CANS are from

50% to 100% stronger than other leading makes. Longer life means lower Can costs. Ask your supply house or write us for complete information.

The complete WITT line includes: Ash, Garbage, Roller, Hoisting, Hooded, Oily-Waste and Underground Cans and Garbage Pails.



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Floor Lamp	✓
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... and we added
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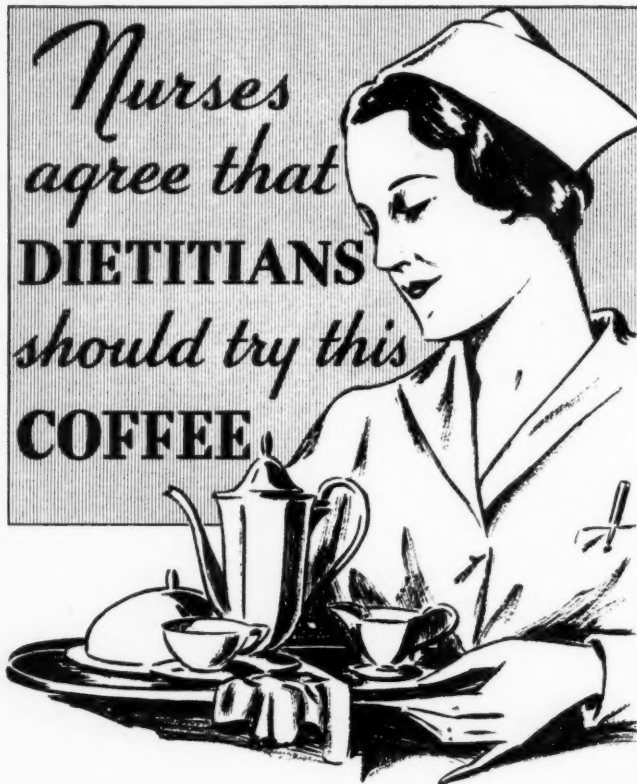
NO wonder the Will Ross Bedside Lamp is popular. Specifically designed for one purpose and one purpose only—a bedside lamp for hospitals. It meets ALL the "must" requirements set up by hospital superintendents and nurses — with color corrected light, handsome lines and beautiful finish added for good measure.

If you are not using the Will Ross Bedside Lamp — start now, with one lamp. Other hospitals tell us it is "the best bedside lamp on the market" and that "there's no other quite like it." We know you'll be more than satisfied.

LT-600-B—Bronze Finished \$9.00 each.

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Continental Coffee is *so good* because it is blended from choice berries grown in five different regions—each adding some fine quality . . . because it is roasted with scientific precision . . . because it is cup-tested four separate times . . . because it is roasted daily and on the way to you within 24 hours.

Every hospital dietitian is invited to get a testing sample of the coffee our Hospital Department has developed for finicky patients.

CONTINENTAL SERVICE

In addition to supplying among the most popular hospital coffees, Continental also provides a complete coffee service. Experts will demonstrate at any time the best method for making the most delicious brew. You can learn the most thorough system of urn cleaning, without which the best coffee is impossible. You can even get from us the most efficient coffee making equipment, made in our own plant.

Ask the Continental salesman who calls on you or write direct to Hospital Department No. 913 for complete information and your test package of Continental Coffee. There is no cost or obligation.

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ALWAYS *Serve* **FOUR** INSTITUTIONAL
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AMERICA'S LEADING

NEWS FROM MANUFACTURERS

NEW FREEZER CUTS ICE CREAM COSTS

A small size ice cream freezer especially designed for use in hospitals is announced by Mills Novelty Company, Chicago. Several hospitals which have used the machine for making ice cream, sherbets and other delights, report that their costs have been reduced more than half compared with the cost of buying these products on the outside.

The new Mills Whirlwind has a 2½-gallon capacity and freezes ice cream in thirteen minutes, it is stated. The freezer, hardener and mix storage are all contained in one unit. The ice cream may be packaged direct from the freezer, if desired, and then placed in the hardener. The entire unit is only 79 inches long and approximately 30 inches wide.

A NEW TYPE OF DOOR HOLDER

Silent, economical door control, positive control of the door in any position and prevention of slamming are absolutely essential in every hospital.

A new and improved type of friction roller door holder which, according to the manufacturer, ensures silent, positive door operation has just been announced by The Stanley Works, New Britain, Conn.

A special offer is being made by the manufacturer in order to acquaint hospitals with the advantages of the new door holder. One of the door holders, it is stated, will be sent, free of charge, to any hospital that will give the device a thorough trial on a room door.

The new Stanley Friction Roller Door Holder is easily applied, it is stated, and adds greatly to the comfort of patients. It operates on any type of floor or floor covering and it is entirely automatic in operation. The holder requires no adjustment.



A RUBBER ELECTRIC HEATING PAD

A new device for applying controlled heat to any part of the human body has been announced by the Seamless Rubber Company, New Haven, Conn. The Electro-Sheet is the name of this new rubber electric heating pad.

In general appearance Electro-Sheet is a solid sheet of rubber about 9 by 13 inches. In the pad itself and the rubber cord leading to the switch there are no electrical or mechanical features visible. Molded and vulcanized wholly inside the pad are two thermostats and an electrical heating unit. Electro-Sheet is a three-heat switch control pad with a low of approximately 115° F., a medium of 135° F. and a high of 145° F.

The pad is designed to operate at 110 volts, either direct or alternating current and on the latter at any number of cycles frequency.

The principal advantages of this device, according to the manufacturer, are as follows: (1) it gives controlled heat; (2) there is no inflammable material; (3) it is nonabsorbent and washable; (4) it will operate five hours for one cent; (5) it is thin, flexible and body conforming; (6) it is waterproof and can be used for moist heat.

ONLIWON TOWEL AND
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LIKE A GOOD INVEST-
MENT ALREADY



EVEN if economy were the only consideration, there would be sound reason for installing A.P.W. Onliwon Towels and Tissue in private rooms. There are any number of uses for which these large, soft absorbent towels are ideal. They are made specifically for their work—and one Onliwon Towel will do where several ordinary towels would be required.

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Find out today how economically and efficiently this practical Onliwon Towel and Tissue dispensing service will fit into your established routine.



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Without cost or obligation, write to A.P.W. Paper Co., Albany, N. Y., for samples and/or name of local distributor as near you as your telephone.

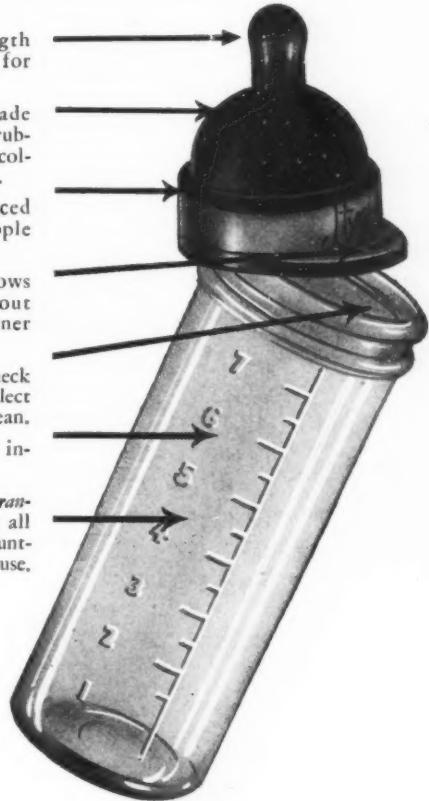
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BOTTLES AND NIPPLES

- 1 Larger top. Length $\frac{3}{4}$ inch. Easier for baby to hold.
- 2 Entire Nipple made of soft moulded rubber. No pores to collect food particles.
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- 4 Patented tab allows handling without contaminating inner surface.
- 5 Wide mouth. No neck or shoulder to collect germs. Easy to clean.
- 6 Smooth, rounded inner surface.
- 7 Strong glass. *Guaranteed* to withstand all temperatures encountered in regular use.



INTESTINAL disorders are still by far the greatest cause of infant mortality, especially during the bottle-feeding period. These disorders are frequently associated with food contamination.

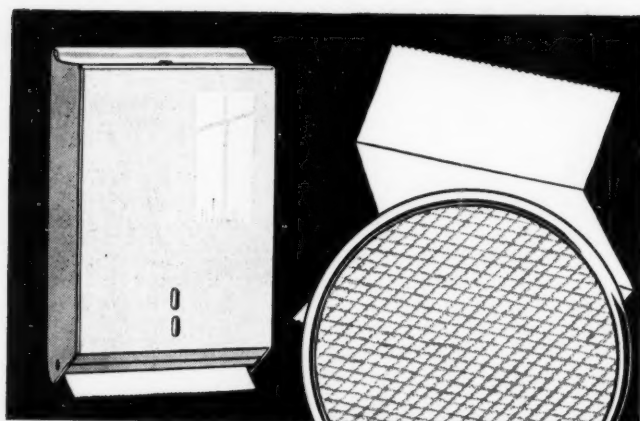
Hygeia Bottles and Nipples are one *economical* means of guarding against such hazards. Six Hygeia Bottles and thirty Nipples, a generous estimate of the quantity required for the entire nursing period, cost only three dollars more than ordinary bottles.

Send for free sample of the newly designed Hygeias. Their many new and exclusive features will convince you of their superiority. Hygeia Nursing Bottle Company, 197 Van Rensselaer Street, Buffalo, N. Y.

Have you tried Hygeia Strained Vegetables?

Hygeia

THE safe NURSING BOTTLE AND NIPPLE

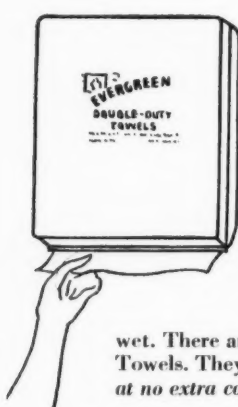


NOW Evergreen TOILET TISSUE IS EMBOSSED FOR SUPER SOFTNESS

Evergreen progressiveness again gives you something new and better in personal-use tissue. Here is a natural-white toilet tissue, with all the well-known Evergreen qualities, plus a distinctive embossed texture. The result is a new incomparable softness and absorbency.

This new toilet tissue is as soft as the most delicate cloth fabric—fluffy as down. It looks like cloth, feels like cloth, and is made antiseptically pure through the Evergreen borating process.

Let the coupon bring you a sample. Examine and compare it with any other tissue you ever saw. You'll see a big difference.



Evergreen PAPER TOWELS

Evergreen Towels win preference because of their linen-like softness. They feel better to your skin—make your skin feel better—give complete drying efficiency. Double-thickness gives Evergreen Towels five to six times more absorbency, and they are stronger when

wet. There are economy and satisfaction in Evergreen Towels. They are impregnated for safety with boric-acid at no extra cost to you.

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Dept. 20. Please send me samples of your NEW Embossed Toilet Tissue, and samples of Evergreen Towels—no obligation.

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THE SURETY OF SAFETY

WAXED PAPER FOR WET DRESSINGS

A waxed paper especially designed for wet surgical dressings has just been placed on the market by The Menasha Products Company, Menasha, Wis. Surgowax, which is soft of texture, conforms to the physical contours of the body comfortably and plially, and is moistureproof and airproof, it is stated.

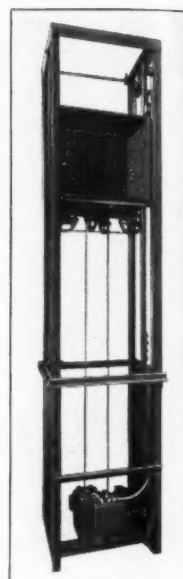
The product is steam sterilized by the manufacturer and, it is pointed out, remains sanitary up to the last inch of the roll because of the specially designed cutter-edge carton in which it is packed.

A PORTABLE DUMB-WAITER

A new type of electric automatic dumb-waiter which has several interesting features has been announced recently by Warner Elevator Mfg. Co., Cincinnati. The outfit can be set up by a mechanic in a few hours. It is portable and can be moved from one location to another.

The equipment is self-contained in a steel hoistway and can be used either under the serving counter or otherwise. No overhead room is required for installation, it is stated. The unit is automatically controlled by push buttons at each landing.

Any rise can be accommodated, but standard frames are built for 10 feet or 12 feet. The motor is 1½ horse power and is placed at the bottom of the shaft on the lower floor. The unit is of the traction type and has a capacity of 350 pounds with a speed of 50 feet a minute. The car is 2 feet 9½ inches by 2 feet 6 inches.



COMBINATION URN AND COFFEE MAKER

An electrically heated combination urn and coffee maker for making coffee by the drip process has been announced by Swartzbaugh Manufacturing Company, Toledo, Ohio. Being insulated, the Ideal Combination Urn may also be used for serving iced beverages, such as milk, tea or coffee.

Coffee is made in this device at a temperature of about 190 degrees. There is a thermostatic control to prevent the water in the urn from getting above this point. This control also functions should the current be left on after the coffee has been made.

The outer body of the urn is of polished monel metal. The inner lining is seamless aluminum, "flint" plated. This special plating process, according to the manufacturer, prevents any metallic taste in the coffee.

The Ideal Combination Urn may be fitted to the Ideal Food Conveyor, it is pointed out, and it may be used as an urn, a coffee maker, or both.

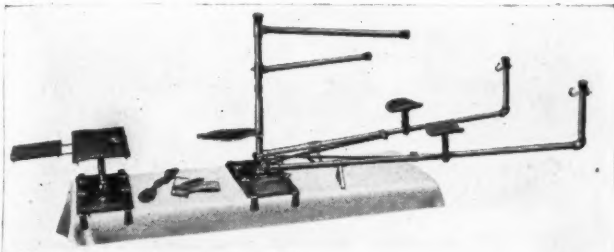
NEW WOOD SEAL FOR FLOORS

A penetrating wood seal designed to harden the surface of floors and impregnate the floor with a rot-resisting combination of natural oils has been announced by Franklin Research Company, Philadelphia.

Chekitt, according to the manufacturer, eliminates costly maintenance, because it stops splintering and dusting, checks decay and does away with the need for sanding and scraping. A coating of wax is applied over the Chekitt treated wood or linoleum floor.

DEPUY

The Name Best Known to Hospitals



PORTABLE FRACTURE TABLE

Will fit any examining table, x-ray table, or library table in the home.

For the application of plaster casts. Duraluminum head and shoulder rest. Cast aluminum pelvic seat. Duraluminum base for standard to rest upon. Leg supports are chromium-plated steel. A handy appliance for the clinic, office, or small hospital \$75.00

Fracture book free upon request

DePUY MFG. CO., WARSAW, IND.

FRACTURE APPLIANCES

THE APPLGATE LINEN MARKING SYSTEM

will be exhibited at Booth 30

A. H. A. 36th ANNUAL CONVENTION Philadelphia

Hospitals find that the full cost of marking linen with the Applegate System is only 3c per dozen. Saves in sorting time alone, 20 to 60 days of time each year in hospitals of 100 to 200 beds. This saving the first year will buy a complete Applegate System.

LOW PRICED MARKERS

Foot Power Marker.....\$30.00
Hand Power Marker.....20.00

INKS, too

APPLGATE'S (heat required). This silver base marking ink will never wash out—will last the full life of any cloth fabric. XANNO (NO heat required). Will last many washings longer than any other ink NOT requiring heat to set.

If you cannot attend the A. H. A. Convention, write for catalogue and sample impression slip.

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ONE OR ALL
AT ONE
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Speed unlimited!

Cut This Out—Take it along

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Investigate the Applegate Linen Marking System shown at Booth 30, A. H. A. 36th Annual Convention, Philadelphia, Penn.

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Sterilizers and Operating Tables will be exhibited at the Convention of the A. H. A., Philadelphia, September 24th to 28th. Booths 39 and 40.

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LIGHT the BI-FLECTOR way

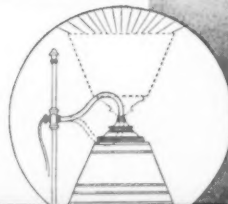
Searchingly bright, cozily dim, intermediate—Here is a superbly designed lamp that is at once a

The Perfect Lamp for the Sick Room

Besides its complete adaptability to every hospital demand—the doctor's, the nurse's, the patient's—Bi-flector is economical to install and maintain.

Why not let us tell you more about Bi-flector? Send your name and address to us now! By return mail we will forward our illustrated folder.

Sixty rooms in the beautiful new St. Joseph's Hospital at Yonkers, New York, are equipped with Bi-flector.



night lamp
(7½ watts) for comfort
direct lamp
for examinations
reading lamp
for the convalescent
nurse's lamp
for the night watch
indirect lamp
for general illumination
economy lamp
total watts used 67

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THE noiseless GENERAL FLOOR MACHINE

The exclusive and Modern Hospital floor machine makes possible proper floor maintenance—easily—quickly and economically.

- Greater efficiency because of its increased brush speed and entire concentration of weight directly over brushes.
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No Gears

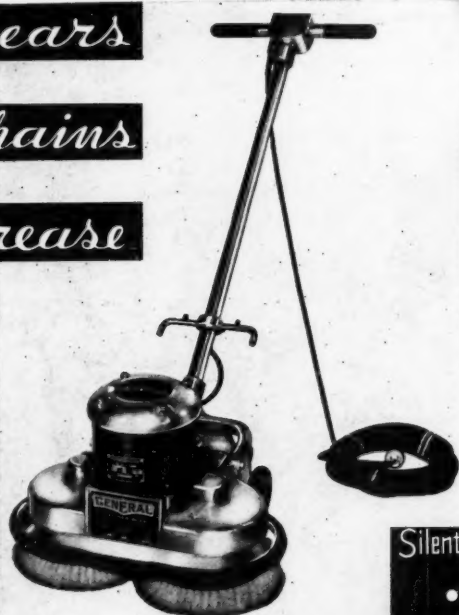
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Model 14 (14" brush spread) for small institutions.

Model 18 (18" brush spread) for all size institutions.

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IMPROVED BLOOD TRANSFUSION SYRINGE

The new B-D Medical Center Blood Transfusion Syringe, manufactured by Becton, Dickinson & Co., Rutherford, N. J., is said to offer an improved method with greater speed of transfusion and less danger of coagulation. There is no metal stopcock in connection with the apparatus. The blood comes in contact with only glass and rubber except where it passes through the needles. The manufacturer states that 500 cc. of blood may be transfused with safety in approximately eight minutes.

A new type of mechanical counter is employed which counts each stroke from one to sixty. The purpose of this is to eliminate the possibility of error, through counting, by the doctor or nurse.

There are three operating positions: 10 cc. transfusing position; 5 cc. transfusing position, and neutral position. In each of the transfusing positions it is only possible to aspirate from the donor and inject into the recipient. This safety factor, it is pointed out, prevents serious mistakes.

NEW TRADE CATALOGUES AND PAMPHLETS

Savory, Inc.—A cross section of a toaster, showing the processes by which a slice of bread is toasted, is an interesting feature of the catalogue published by Savory, Inc., Newark, N. J. It is stated that this machine is fully automatic and that no attendant's time is required in making adjustments or removing the toast. Low cost of installation and maintenance, and cleanliness in operation are also claimed.

Wilmot Castle Company—A colorful folder from the Wilmot Castle Company, Rochester, N. Y., portrays the Victory, a new sterilizer and wash bowl combination. With one unit, the doctor can wash his hands, sterilize his dressings, scrub and sterilize his instruments. A top of one-piece unbreakable china with porcelain finish is an attractive feature.

American Radiator Company—A radiator for hospitals where sanitation is imperative is shown in a folder from the American Radiator Co., 40 West Fortieth Street, New York City. There are no dust catching edges built into the radiator. Other literature issued by this company includes the Arco convector which is adapted for steam, vapor or hot water heating systems.

Frick Company, Inc.—The uses and construction of low pressure refrigerating units are set forth in a new "Ice and Frost" bulletin of the Frick Company, Inc., Waynesboro, Pa. Charged with either methyl chloride or freon, said to be an excellent refrigerant for use in small refrigerating systems, these units are supplied in more than twenty types and sizes.

The Colson Company—A folder from The Colson Company, Elyria, O., introduces a new Safety Inhalator, utilized in the treatment of respiratory diseases. Portable and electrically operated, the inhalator is described as compact, absolutely safe and easy to use.

John E. Smith's Sons Co.—Attractive literature from John E. Smith's Sons Co., Buffalo, N. Y., presents modern food cutting equipment. Food choppers, including the self-emptying model, are emphasized. Recently developed machines are a small vegetable slicer built for heavy duty, and a similarly constructed meat grinder.

The Formica Insulation Company—A molded table top to fit any standard bedside table is illustrated in a folder issued by The Formica Insulation Company, Cincinnati. These tops are available in twenty different colors.